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Access the manual via the Open Dental website (www.opendental.com) or from within Open Dental, MainMenu, Help:

Online Help - Contents: Opens this page.
Online Help - Index: Opens the Search page.

? Customers on support may click the Help Icon at the top of each window within the Open Dental program to open the corresponding manual page.
A printable pdf version of this manual is available: Manual19_3.pdf. It's a large 110 MB download that's 1700 pages long. It does not include the technical section of the manual. It's not very useful because it lacks hyperlinks. A better approach is usually to use two monitors, one for the manual and one for the software.

Module
Open Dental has one main window with seven modules. This makes navigation easy and keeps the screen and task bar uncluttered.

To switch modules, click the associated button in the vertical toolbar on the left side of the window.
- Appointments Module
- Family Module
- Account Module
- Treatment Plan Module
- Chart Module
- Images Module
- Manage Module

Two Modules Open at Same Time: Sometimes you may want two modules open at the same time. For example, you may want to view the appointment schedule while managing accounts. Or perhaps you want to compare two different patients side by side. In these scenarios, simply open two instances of Open Dental.

Appointments Module
The Appointments Module is where patient appointments are scheduled.
From here you can see the appointments for the day or week at a glance, and easily manage and schedule appointments.

The Appointments module shows the appointments for the current day or week. Change the day/week using the calendar.

**Day** or **Week** view: Set using the radio buttons under the calendar. Set a default in Appointments Module Preferences.

- **Day**: Grid will be divided into operatories.
- **Week**: Grid will be divided into seven days (Monday through Sunday). The appointments will appear narrow, so hovering over the appointment to view bubble popups may be useful. Move appointments within the current week by dragging and dropping, or use the pinboard.

**View**: Appointment Views determine the operatories and providers that show and the information that shows in an appointment. It also determines the default start time when Open Dental is first opened.

- Click the dropdown to change views or press an associated function keys across the top of your keyboard.
- The default appointment view when a user logs on will be the same view active when the user last logged out.

When **Clinics** is turned on, the appointment views are associated with specific clinics. Changing the clinic in the main menu will change the appointment view options and the appointment view. The default view when a user logs on is based on several settings defined in Appointments Module Preferences, User Edit, etc.

**Time**: Use the vertical scrollbar to move through the entire 24 hour day. The time increment is a global setting. See Time Increments in Appointment View Setup.

- The default start time is determined by the selected appointment view. It can be a set time or dynamically start at the earliest appointment or provider time.
- Current time is indicated by a horizontal time line that automatically moves down every minute. Customize the line color in Appointment Module Preferences.
- Vertical Time Bars show as color-coded visuals of appointment length and provider time.

**Operatories**: Define operatory names, colors, and order in Operator Setup.

- Click on a operatory header to view the default provider's name and specialty, the name of scheduled providers, their time blocks, and note, any note for the selected clinic, and the daily production totals for the operatory.
Hover over an appointment header to view provider name and production totals.
Right-click on an open time block in the operatory to add, edit, or clear Blockouts(10).

**Colors:** By default, white areas indicate open times, grey indicates closed times (see Schedule Setup(1099)).

**Appointments:** Basic appointment details show in an appointment box. Double click the box to open the Edit Appointment Window(20) or right-click to select more options. Every appointment has a second optional provider for hygiene so that only one appointment has to be made even if a patient is technically seeing two providers.
Depending on your preferences, appointment details may pop up when you hover over the appointment. To customize the appointment bubble, see Display Fields(900).
As appointments are set complete, they are greyed out by default.
Broken appointments are marked with an X.
To move an appointment, simply click and drag it to a different time, day (in Weekly view), or to the pinboard.

**Right-click options:**

- **On an Appointment:**
  - Copy to Pinboard: Copy the appointment to the pinboard.
  - Send the appointment to the Unscheduled List(41).
  - Break Appointment: Break an appointment. See Breaking Appointments(55).
  - Mark as ASAP: Mark the appointment as ASAP and add it to the ASAP List(43).
  - Set Complete: Set the appointment complete. See Setting Appointments Complete(54).
  - Delete: Delete the appointment. See Deleting Appointments(57).
  - Other Appointments: View all appointments for the selected patient and family members. See Patient Appointments(24).
  - Print Label: Print single appointment reminder Labels(1708).
  - Print Card/Print Card for Entire Family: Print a future appointment reminder postcard for a single patient or family. Reminder cards cannot be customized.
  - Routing Slips: Print Routing Slips(1302).
  - Go To Ortho Chart: Open the Ortho Chart(390) for the selected patient. Only shows when information exists in the Ortho Chart or this option is enabled in Ortho Setup(927). Customize the text that shows in Ortho Chart Setup(392).
  - Call Home Phone: Click to call the home phone for the selected patient. Requires an additional service. See DentalTek Bridge(970).
  - Call Wireless Phone: Click to call the wireless phone for the selected patient. Requires an additional service. See DentalTek Bridge.
  - Send Text: Send a text message. Opens a blank text message window. See Sending a General Text Message(1675).
  - Send Confirmation Text: Send a text message using the default confirmation message. See Confirmation List Setup(612).

- **On an Empty part of the Schedule:**
  - Blockout Options: For detailed breakdown of these options see Blockouts(10).
  - Text ASAP List (manual): Open ASAP List(43).
  - Text Appointments for Day, Op only: Opens window below. Allows you to send the same message to all patients with an appointment in the operatory and day based on where you right-click.
Note: For multiple patients with the same wireless number a single message will be sent.

- Text Appointments for Day, Current View only: Same as above, but for all appointments in the current Appointment View (7).
- Text Appointments for Day, Clinic only: Same as above, but for all appointments for the currently selected Clinic (1505).
- Update Provs on Future Appts: See Update Provs on Future Appts (54).

**Toolbar**

A small toolbar shows above the calendar.


Print a list of appointments that you can post in areas where you do not have monitors. The current setting for Day or Week view will determine if a daily or weekly list is printed. Time increments and rows per increment set in appointment views can affect printing. If too many pages are still printing, increase the time increment or set the rows per increment to one.
• **Start / Stop Time**: Enter specific times to include in the list.
• **Operatories per page**: Directly affect how many pages will print. More operatories per page will result in less printed pages.
• **FontSize**: Affects how many pages will print.
• **Preview**: Review the print output.
• **Save**: Save settings for the next time you print.
• **Print**: Print the schedule.

**Print Routing Slips**: Print routing slips for appointments on the schedule for the selected day. Not available if Headquarters is the selected clinic, or if Week view is selected.
• **All for Day**: Print all routing slips for the selected day and clinic.
• **Current View Only**: Print routing slips for the selected appointment view.

**Rapid Call**: If the DentalTek Rapid Call Bridge (1056) is enabled, launches the Rapid Call application. Otherwise, opens the DentalTek Rapid Call website.

**Calendar**
The day or week currently selected lists above the calendar. Today's date is surrounded by a square. Click on a date to quickly jump to the day/week in the schedule.
• Change the day: Click on the new date, or click the blue arrows to jump back/forward one day.
• Change the week: Click the blue W arrows to jump back/forward one week.
• Change the month: Click the arrows to the left/right of the month to jump back/forward one month at a time, or click the blue M arrows below the calendar.
• Change the year: Single click on the month header (e.g. September 2013), then single click on the year to show a 12 year grid.
• Today: Jump to today's date.

**Pinboard and Searching for Openings**
The Pinboard (14) can be used for easy scheduling between days or weeks. Drag or send appointments to the pinboard, then drag onto the schedule. You can also search for openings.

**Other Information**
**Lab Cases**: Indicates the status of lab cases for the selected date. If clinics is turned on, only the status of lab cases attached to appointments scheduled in the selected clinic's operatories, for the selected date will show. If Headquarters is
the selected clinic, the status of all lab cases attached to appointments scheduled in all operatories for the selected date is shown (including those not associated with a clinic). See Dental Lab Cases(379).

**Daily Prod:** View the daily production sum. Production must be added to the appointment view in order to view a value. Also see Production Totals(15).
- By default, the value reflects the daily production sum for all procedures attached to appointments where at least one provider has a provider bar showing in the appointment view.
- To instead calculate the sum for all procedures scheduled in operatories that show in the appointment view, check Appointment module production use operatories in Appointment Module Preferences.
- To calculate adjustments in the net production total, see Appointment Module Preferences, Add daily adjustments to net production.
- If the gross and net amounts are the same, only one number shows.
- If you see two numbers, the first number is the gross (sum) of the procedure fees. The second number is the net after subtracting all write-offs and write-off estimates.
- Write-offs will be used when viewing dates in the past; estimates will be used when viewing current or future dates.

**Daily Goal:** View the total daily production goal for all scheduled providers in the appointment view. The value is calculated using the hourly production goals for each scheduled provider, as entered on the Edit Provider Window(1255). Production or NetProduction must be added to the appointment view.

**Action Buttons:** Show to the left of the list of confirmation statuses. Quickly send an appointment to the Unscheduled List, break it, set it complete, or delete it.

**Confirmation Status:** Quickly change an Appointment Confirmation Status(17). The option is grayed out if the user does not have the ApptConfirmStatusEdit security permission. Some statuses trigger Time Arrived, Time Seated, and Time Dismissed values, which affect the waiting room. Status options can be customized in Definitions, Appt Confirmed.

**Appointment Buttons**

**Make Appt:** Schedule an appointment.
- If this is an appointment for a new patient, or the patient has only completed appointments, the Edit Appointment Window will display.
- If the patient has scheduled, broken, unscheduled, or planned appointments, the patient’s appointment history will open so you can check appointment history before scheduling.

**Make Recall:** Schedule the patient's next Recall Appointment(140). Patient must be due for a special recall type, meaning a special trigger procedure has been completed. Otherwise, a message will indicate no recall is due.
- If the patient has a scheduled appointment, or an appointment on the Unscheduled List, the patient’s appointment history will open. Otherwise the appointment is copied to the pinboard.
- When copied to the pinboard, if the treating provider is scheduled in an operatory, and if in Day view, the calendar will jump to the recall due date or the next date that has an availability for the appointment length. It does not automatically search for availability if in Week view.
- Custom recalls that are not a special recall type cannot be scheduled using Make Recall, UNLESS the patient is also due for a special recall type. If so, then Make Recall will schedule one recall appointment for all recalls due. If the patient is only due for a custom recall type, click Make Appt to schedule.

**Fam Recall:** Schedule recall appointments for all family members. Similar behavior as Make Recall.

**View Pat Appts:** View the patient's appointment history and family recall information. See Patient Appointments(24).

**Waiting/Emp/Prov/Reminders Tabs**

**Waiting:** See Waiting Room(16).

**Emp:** View scheduled hours for employees for the selected day. Only employees scheduled in the selected clinic are listed. Double click anywhere in the grid to edit the schedule.

**Prov:** View scheduled hours for providers for the selected day. Only providers scheduled in the selected clinic are listed. Double click anywhere in the grid to edit the schedule.
Reminders: View all Task Reminders(1701) for the logged on user that are due for the current day, ordered by date and time. Reminders will only show here through the end of the current day. An asterisk appears in the reminders tab when there are reminders for the current day.

Appointment Views
In the Appointments Module(1), on the right, under the pinboard, is the Appointment View dropdown.

Appointment views determine which operatories, providers, and appointment information will show in the Appointments Module. They also determine the default start time when Open Dental is launched. Multiple views can be set up with any combination of operatories, providers, and patient or appointment information.

Also see:
Appointment View Setup(621)
Appointment View Edit(622) (description of all options)
Proc Appt Colors(626)

Select the appointment view using the View dropdown on the right side of the Appointments module or press an associated function key (F1, F2, etc.) across the top of your keyboard.

The appointment schedule will immediately change to reflect the appointment view settings.

Appointment view examples:
• HIPAA compliant view (no PHI)
• A view for each doctor
• A view for each operatory
• Hygiene appointments

When using Clinics(1505), changing the clinic in the main menu will change the appointment view.

The default appointment view when a user logs on will follow this logic in this order:
1. The same view active the last time the user logged out.
2. The view last active on the workstation.
3. The first available view that is not none.
4. If no other views, the none view.

The None view cannot be edited. When a view is set to None you will see all providers, all operatories, the patients first and last name, and procedures attached to the appointment. If you are using clinics, and you select None on Headquarters, you will be prompted to select a view.

Note: To indicate open/close times on the schedule, see Schedule Setup(1099).

Time Bars
In the Appointments Module(1), vertical time bars show on the schedule as color-coded visuals of appointment length and provider time.
• By default, each square in the time bar is 10 minutes. To change see Time Increments in Appointment View Setup(621).
• Colored squares indicate provider time. The color is based on the provider's appointment color as set on the Provider(1255).
• White squares indicate non-provider time.
• Abbreviated notes can be added to the time bar from the Edit Appointment window.
• Hygienists: If the appointment is marked as Is Hygiene on the Edit Appointment(20) and a hygienist is assigned, the hygienist is considered the provider and thus is indicated with colored squares (the hygienist's appointment color). If not marked Is Hygiene, the hygienist is not considered the provider and the time will be indicated with white squares.

Appointment Time Bar: Shows on the left edge of every scheduled appointment. The bar indicates appointment's length and provider time. Appointment time bars can be disabled in the Appointments Module Preferences(608).

Provider Time Bars: Show on the far left of the appointment schedule, to the right of the time indicator, for all providers visible in the current appointment view. Each bar indicates provider time for an appointment based on the scheduled appointment's time pattern. Hover over the colored rectangle above the time bars to see the associated provider's name.

Operatory Time Bars: Show to the left of an operatory to indicate the primary and secondary provider scheduled in the operatory. Up to two bars may show: one provider and one non-provider. The operatory time bars only show when an operatory has been assigned to a provider's time block in the schedule (Schedule Setup(1099)).

Edit Provider/Assistant Time and Appointment Length
Provider time, assistant time, and appointment length is calculated automatically based on the time pattern of the procedures attached to the appointment. Time and length can be changed by editing the time pattern of the appointment or the time pattern of procedures.

Time Pattern of the Appointment: On the Edit Appointment window, an appointment time bar shows on the left.

Click and drag the slider (solid grey rectangle) to increase/shorten appointment time, or simply click on a square to increase appointment time. Click on a square to toggle between provider time (colored squares) and non-provider time (white squares).

Abbreviations can be added to the right column which then appear on the appointment.

Once you change an appointment's time pattern on this window, the appointment's time will be locked and any procedures added later will not automatically adjust the appointment time pattern.
**Time Pattern of the Procedure Code:** Every procedure code has a time pattern as part of its definition on the Procedure Code (1200).

X indicates provider time (e.g. doctor or hygienist) and / indicates non-provider time (e.g. assistant time). Click a square to toggle between / and X. Click and drag the slider to lengthen the procedure's total time.

---

**How Appointment Time is Calculated**

When calculating appointment time, Open Dental follows the logic below:

One procedure: If there is only one procedure selected for an appointment, the appointment time pattern is the same as the attached procedure.

Multiple procedures:
- The procedure time patterns are combined when more than one procedure is added to the appointment.
- All provider (X) time is added together. Non-provider (/) time appears at the beginning and end of the pattern if it exists on the procedure.
- Non-provider time is not added together. Instead, the maximum amount of non-provider time on a procedure is added to the appointment. For example, if a procedure with ten minutes of non-provider time and a procedure with forty minutes of non-provider time are attached to an appointment, the appointment will show forty minutes of non-provider time.

Example: You attach 3 procedures to the appointment with the following time patterns:
- MOD amalgam - /XXX/
- Extraction - /X/
- Crown prep - /XXXX///

The resulting appointment time pattern is: /XXXXXXXX///
- The first three Xs are the amalgam.
- The fourth X is the extraction.
- The last four Xs are the crown prep.
- The first slash and last four slashes show the maximum non-provider time for all procedures on the appointment.

On the Edit Appointment window the appointment time pattern will look like this:
To create custom time patterns for multiple procedures attached to an appointment, see Appointment Types (619).

Additional examples: The following examples show the individual procedure time patterns, and the resulting time pattern when multiple procedures are added to an appointment.

\[
X + X = XX/X + X = /XX/X/ + /X/ + /XX/ + /XX/ = /XXXXXXXX///XXXX/ + X/ = //XXX////XXX/ + /X// = //XXX//
\]

**Double and Triple Booking**

When one provider has two or more appointments scheduled for the same time block, the Provider Time Bar will indicate the conflict.

- If two appointments are scheduled in the same time block (double booked), diagonal lines in the square will indicate the conflict.
- If three or more appointments are scheduled in the same time block (triple booked), solid black squares indicate the conflict.

To block double booking of provider time by procedure, see Appointment Rules (617).

**Blockouts**

In the Appointments Module (1), blockouts show as colored areas.
Blockouts change the background color of the schedule, can be set to enforce scheduling, and are visible from Mobile Web. Appointments can be scheduled on top of certain blockout types.

The Blockouts permission is required to add, edit, cut/copy/paste, and delete blockouts that are not flagged as Disable Cut/Copy/Paste (DC) or No appointment scheduling (NS).” (DC). Users without the permission can only add, edit, and delete blockouts flagged as DC and NS.

Blockouts cannot overlap. When adding a blockout that would overlap an existing blockout, you will get a message stating blockouts cannot be overlapped, or you will be prompted to remove the existing blockouts. This behavior is determined by the Allow ‘Block appointment scheduling’ blockouts to replace conflicting blockouts preference in Appointments Module Preferences(608).

Define blockout types, scheduling preferences, editing preferences, and colors in Definitions: Blockout Types(852). Define the font color in Definitions: Appointment Colors(843). To use outlines instead of solid blocks of color, see Appointments Module Preferences(608). To use dummy appointments as a quick way to post a note, see Notes(320).

To view or select a blockout option, right-click on the operatory in the schedule.

- **Edit Blockout**: Change an existing blockout.
- **Cut Blockout**: Remove an existing blockout from the schedule, but retain it in memory.
- **Copy Blockout**: Copy an existing blockout to the clipboard.
- **Paste Blockout**: Insert a cut or copied blockout in the time and operatory indicated by the mouse.
- **Delete Blockout**: Permanently remove a blockout.
- **Add Blockout**: Create a new blockout.
- **Blockout Cut-Copy-Paste**: Quickly copy and paste blockouts by day or week. See below.
- **Clear All Blockouts for Day**: Remove all blockouts for the current day. A confirmation message will show. This option is not available when Clinics is enabled.
- **Clear All Blockouts for Day, Op only**: Removes all blockouts for the day in the selected operatory only. A confirmation message will show.
- **Clear All Blockouts for Day, Clinic only**: Removes all blockouts for the day for the selected clinic only. A confirmation message will show.
- **Edit Blockout Types**: Quickly jump to Definitions: Blockout Types to set up blockout types.

Note: Cut Blockout, Copy Blockout, and Paste Blockout items will be gray if the blockout has Disable Cut/Copy/Paste checked in Definitions.

**Add or Edit a Blockout**

On the appointment schedule, right-click on a time block in an operatory, then click Edit Blockout or Add Blockout. Edit Blockout is only enabled when you right-click on an existing blockout.
### Edit Blockout

<table>
<thead>
<tr>
<th>Start Time</th>
<th>Stop Time</th>
<th>Blockout Type</th>
<th>Operators</th>
</tr>
</thead>
<tbody>
<tr>
<td>11:00 AM</td>
<td>12:00 PM</td>
<td></td>
<td>Doc 1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lunch</td>
<td>Doc 2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Do Not Schedule</td>
<td>Hgy 1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Emergencies</td>
<td>Abby</td>
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<td>Bela</td>
</tr>
</tbody>
</table>

**Start/Stop Time:** Both times default to the time clicked on the schedule. Manually change times or click the dropdown to select an option. You are not required to use 30 minute increments. If manually entering, use the format 00:00 AM.

**Note:** Optional text that shows under the blockout label. This text box has right-click options ([Right Click Text Box](319)).

**Blockout Type:** Determines the blockout text, scheduling and editing preferences, and color. Customize options in Definitions, Blockout Types.

**Operators:** The operators the blockout will apply to. To select multiple Operators(628), press Ctrl while clicking. If using Clinics(1505), only operators assigned to the clinic selected in the main menu are options.

When blockouts with the same type are added to multiple operators at once, they become connected. Deleting or replacing a blockout in one operator will also delete or replace any blockouts that are connected.

**Blockout Cut-Copy-Paste**

Use this tool to copy and paste blockouts for a week or day. Changes only apply to the visible operators for the current appointment view. Blockout types with Disable Cut/Copy/Paste checked in Definitions are not included.

1. In the Appointments module, move the schedule to the day you want to act on.
2. Right-click on the schedule and select Blockout Cut-Copy-Paste.
3. Select an option.

**Clear Day**: Remove all blockouts on the selected day (daily or weekly view).

_Note:_ When Clinics is enabled **Clear Day** will only clear the day of the selected clinic.

**Copy Day/Paste**: Once one day’s blockouts are set up, copy and paste it to other days.
1. Click Copy Day. The window will close.
2. Right-click on the day you want to paste to, and select Blockout Cut-Copy-Paste again. The copied date will show.
3. Click Paste.

**Copy Week/Paste**: Once an entire week's blockouts are set up, copy and paste to other weeks.
1. To include weekends in the copy, check **Include Weekends**.
2. Click Copy Week. The window will close.
3. Right-click on the week you want to paste to, and select Blockout Cut-Copy-Paste again. The copied date range will show.
4. Click Paste.

**Copy/Repeat**: Copy and paste one day or one week repeatedly into the future.
1. Copy the day or week.
2. On the first day/week you would like to paste to repeatedly, right-click and select Blockout Cut-Copy-Paste again.
3. In the # box next to Repeat, enter the number of days/weeks in the future you would like to paste the blockouts, such as 365 days or 52 weeks.
4. Click Repeat.

**Replace Existing**: If checked, the day or week being pasted/repeated will replace any existing blockouts. If unchecked, existing blockouts will not be replaced, and the paste process will stop and go no further than the first conflicting blockout.

Hint: To clear multiple days or weeks, create one blank day or week, make sure Replace Existing is checked, then Copy/Repeat.
Pinboard

In the Appointments Module(1), on the right under the calendar, is the Pinboard area.

The pinboard is a useful tool for moving or scheduling appointments.

To schedule an appointment, simply send appointments to the pinboard, select a different day or week, then drag the appointment to the new date/time. You can send appointments to the pinboard in several ways:

- Drag an existing appointment from the appointment schedule to the pinboard.
- When viewing Patient Appointments(24), click Copy to Pinboard. Or, double click the planned appointment in the Appointments for Patient grid and click Pinboard.
- From the Recall List(27), click Sched Family or Sched Patient.
- From a Planned Appointment(325), click Copy To Pinboard.

You can have multiple appointments on the pinboard at one time. Press Clear to empty the pinboard and return any existing appointments to their originally scheduled time.

Openings in View

If your schedule is booked out for more than a few days, manually searching for a slot can be time consuming. Instead, easily search for available openings.

Note: Schedules must be set up for the search to work, as search results show openings for scheduled providers in the selected appointment view. To control search behavior, see Appointments Module Preferences(608).

Place the appointment on the pinboard and click Search.
The first available time slots will show for each of the next 10 available days. Click **More** to see the next 10 results. Click on any date to jump to it in the schedule.

- **After (Date):** Click the dropdown to select a date from a calendar.
- **Before/After (Time):** Enter the time restriction to search. Entering both a before time and an after time searches for openings between the two times. For example, enter Before 4:00 pm and After 12:00 pm to return openings from 1:00 pm to 3:00 pm if available.
- **Providers:** Lists providers currently included in the search. Click Providers to select from the Provider list.
- **Hygienists:** Immediately search all providers who are hygienists. This will only show non-providers who are selected in the appointment view.

Results can be filtered by date, time, or **Provider**. If you change criteria, click Search again to refresh results.

Time slots in blockouts that do not allow appointment scheduling are not included in the results. See **Blockouts**.

If a user is restricted to a clinic, search results will only appear for openings in the clinic the user has access to.

When you find a suitable date, drag the appointment off the pinboard, then click X or Close to exit.

**Advanced Search**

To search for an available appointment based on additional qualifiers, click **Advanced**.

The Advanced Appointment Search window includes all the same options for searching by date, time and provider. Additionally you can specify a blockout type, clinic, and an appointment view.

- **Note:** Blockout types with the Do Not Schedule type will not appear in the dropdown list.
- Selectable clinics will be restricted based on the current user restrictions, if any.
- Appointment Views are only searchable is the clinic is set to **Unassigned**.

**Production Totals**

In the **Appointments Module**, at the right, production and daily production goals can be viewed.
Daily Prod: By default, the value reflects the daily production sum for all procedures attached to appointments where at least one provider has a provider bar showing in the appointment view.

Daily Goal: View the total daily production goal for all providers scheduled in the appointment view. The value is calculated multiplying the hourly production goal by the hours scheduled for the provider. Hourly goals are entered on the Edit Provider(1255) window. Production and provider bars must be added to the appointment view.

To show a value in this field:
- Production or NetProduction must be added to the Appointment View(7).
- Providers must be associated to the appointment view.
- If using Clinics, appointments must be assigned to the clinic selected.

Only one amount shows when gross and net amounts are the same. If two amounts show, gross and net amounts are different.
- The first number is the gross (sum) of the procedure fees.
- The second number is the net after subtracting all write-offs and write-off estimates. Write-offs will be used when viewing dates in the past; estimates will be used when viewing current or future dates.

Production by Operatory: Hover over an operatory header, or single-click on the header to view production totals for the operatory.

Appointments Module Preferences(608) that affect the value:
- Appointment module production use operatories: Calculate the value based on the sum for all procedures scheduled in operatories that show in the appointment view. This preference ignores any providers on the appointments.
- Add daily adjustments to net production: Controls whether or not adjustments are included in the net production total. The net production on appointments may not equal net production total if adjustments are not attached to procedures.

Note: To view actual production numbers, see Production and Income Reports(1281).
- Net production can be greater than gross production if a patient in the appointment view has received a refund.

Waiting Room
In the lower right corner of the Appointments Module is the Waiting Room. It is used to track patients who have arrived for their appointment.

Patients who list in the waiting room have a Time Arrived, but not a Time Seated entry on the Edit Appointment.

Automated entries for Time Arrived and Time Seated are triggered by Confirmation Status. The default Time Arrived trigger is Arrived. The default Time Seated trigger is In Treatment Room. Change the triggers in Appointments Module Preferences.

Patients who self check-in using eClipboard will be automatically entered in the Waiting Room.

How it works
1. When the patient arrives, click on their appointment. This will select the patient.
2. On the right, click the confirmation status abbreviation that triggers a Time Arrived entry (e.g. Arrived).

The patient will list in the waiting room.
3. When patient is seated, select the status that triggers Time Seated (e.g. In Room). The patient will no longer show in the waiting room.

Additional Appointment Module Preference Options
- Waiting Room alert time in minutes, Waiting room alert color: Use text color to flag patients whose wait time exceeds a certain value.
- Filter the waiting room based on the selected appointment view.
- Refresh every 60 seconds. Keeps waiting room times refreshed.

When using clinics, the patients that show in the waiting room are based on the clinic selected in the Main Menu. If Headquarters is the clinic, all patients waiting for all clinics will show.

Troubleshooting
If you accidentally select a confirmation status that inserts a Time Seated entry but want the patient to remain in the waiting room, double-click the appointment and remove the Time Seated value.

Confirmation Status
In the Appointments Module, a small circle can be added to an appointment box to indicate an appointment's confirmation status (e.g. confirmed, unconfirmed, called, emailed).
To show the confirmation circle, add it to the appointment view.

- In the Main Menu(592), click Setup, Appointments, Appointment Views(7).
- Select the view.
- Add Confirmed Color to the Rows Displayed and select the location (e.g. Upper Right Corner).

Only users with the Appointment Confirmation Status Edit security permission can change the confirmation status. Changes to confirmation status are logged in the Audit Trail(1424).

- Manually changing status via the Confirmation List.
- Sending a postcard, email, or text message from the Confirmation List.
- Sending or receiving an automated eConfirmation.
- When a patient responds to an eConfirmation with a confirmation code or via a URL link.
- Changing the Confirmed option on the Edit Appointment window.
- Changing the confirmation status in the Appointments module.

Add or Edit Confirmation Status Options

Confirmation status options and colors can be defined in Definitions, Appt Confirmed.

In the main menu, click Setup, Definitions(835).
The following status options are created by default:

- Not Called (White)
- Unconfirmed (Red)
- Appointment Confirmed (Green)
- Left Message: (Yellow)
- Arrived: (Orange)
- Ready to go back: (Purple)
- In Tx Room: (Blue)
- Front Desk: (Gray)
- E-mailed
- Texted

- eConfirm statuses: These status options apply to eConfirmations. To set defaults for each action, see eConfirmations(1620).
  - eConfirmSent: The status typically applied when an eConfirmation is sent.
  - eConfirmCallBack: The status typically applied when patient requests a call back on an eConfirmation.
  - eConfirmFailure: The status applied when there is an eConfirmation delivery failure.

- Created from Web Sched: The status typically applied when an appointment is scheduled using Web Sched Recall or Web Sched New Patient. See Web Sched Recall(1600), Web Sched New Patient(1586).
Highlight Appt Confirmed. Click **Add** or double-click a status to edit.

![Edit Definition](image)

**Name**: Enter the confirmation status.

**Abbrev**: Enter the abbreviation of the status.

**Color**: Click the color box to associate a color with this status (the color of the circle when an appointment has this status).

**eConfirmations**: Set whether this status should affect the sending of eConfirmations or the automatic update of confirmation status.
- **Exclude when sending**: When checked, appointments with this status will not be sent eConfirmations.
- **Exclude when confirming**: When checked, appointments with this status will not have their status updated if an eConfirmation is sent.

**eReminders / Exclude when sending**: Set whether this status should affect the sending of eReminders. When checked, appointments with this status will not be sent eReminders.

*Note: eReminder and eConfirmation exclude when sending options are not available for statuses that have been set as triggers for Time Arrived, Time Seated, Time Dismissed in [Appointments Module Preferences](608).*

Click OK to save.

The status listed first is the default for all new appointments, thus usually **Unconfirmed** is the first status listed. To remove a confirmation status as an option in various areas, check Hidden.

**Questions and Answers**

**Reset confirmation status? popup**
This popup can appear when moving an appointment. Three criteria must be in place before this popup will appear:

1. The appointment is scheduled on any date other than today.  
2. On the Edit Appointment window, the selected confirmation status is not the first status in the dropdown list.  
3. The appointment is being moved to a new time on the same day.

**Edit Appointment**

In the [Appointments Module](1), with a patient selected, double-click on an open area to create a new Appointment.
Alternatively:

- In the Appointments Module, double-click an existing appointment to edit.
- In the Appointments Module, click Make Appt, Make Recall, or Fam Recall.
- In the Patient Appointments (24) window, click Copy to Pinboard, Schedule Recall, Entire Family, or Create New Appt.
- In the Recall List (27), Unscheduled List (41), or Planned Appointment Tracker (39), double-click an appointment row.

You can also allow patients to schedule their own appointments online using Web Sched Recall, Web Sched New Patient, or Web Sched ASAP. See Web Sched Feature.

- Note: When scheduling a procedure with an insurance frequency limitation, and Frequency Limitations (104) is enabled, a warning will popup if a frequency conflict is detected.
- A warning will popup when scheduling an appointment for a patient who is on the Unscheduled List (41). You can continue to create the appointment or schedule the appointment on the Unscheduled list.
- To prevent staff from creating appointments with no procedures attached, see Appointments Module Preferences (608).
- To blockout appointment times in operatories, see Blockouts (10).

**Title Bar:** Shows the patient name, appointment day, date, and time, and the appointment's operatory.
**Time Bar:** Along the left side is a color-coded time bar that indicates appointment length. The default appointment time is based on the procedure’s time pattern. The total length of the appointment will display. See Time Bars(7).
- To shorten or increase time, drag the slider up or down.
- Click on a square in the left column to toggle between provider/non-provider time. Colored squares indicate provider time; white squares indicate non-provider time.
- Change the width of the time bar in the Appointments Module Preferences(608).
- Type into the right column to add any abbreviations you want noted on the appointment.

**Status:** The appointment's current status.
- Scheduled: The appointment is scheduled.
- Complete: The appointment has been Set Complete(54).
- UnSched List: Sends an appointment to the Unscheduled List(41). The option is grayed out if you are accessing this window from the Unscheduled List and an appointment has not been scheduled.
- Broken: The appointment has been Broken(55).

**ASAP:** Marks the appointment as ASAP and add it to the ASAP List(43). This means the patients wants to come in sooner if an opening becomes available. ASAP can also be a set as a display option in Appointment Views(7).

**Unscheduled Status:** Used in the Unscheduled List, Recall List(27), and Planned Appointment Tracker(39) to easily identify why an appointment has not been scheduled and determine whether to contact patient or not. Customize options in Definitions: Recall / Unsched Status(887).

**Confirmed:** The Confirmation Status(17). Confirmed statuses are also linked to Time Arrived, Time Seated, and Time Dismissed values (see below).

Note: To also indicate confirmed status in the appointment box on the schedule, add Confirmed Color to the appointment view. A small colored circle will show.

**New Patient:** This box automatically checks on the first appointment created for a patient. When checked, NP will show in the upper left corner of the appointment box on the schedule. Additional appointments (even if scheduled prior to the first appointment created) will not be marked New Patient. To remove the designation, manually uncheck the box.

**Clinic, Dentist, Hygienist:** When an appointment is scheduled in an operatory with an assigned clinic, dentist, or hygienist, the values are usually set according to the operatory's defaults.
- Clinic: The patient’s default clinic. Only visible when Clinics(1505) is turned on.
- Dentist/Hygienist: The appointment dentist and hygienist (provider). Every appointment must have a dentist and can optionally have a hygienist. When an appointment is set complete, the procedures on the appointment automatically get assigned to the dentist and/or hygienist. For example, exams can be assigned to the dentist, while the prophy and x-rays get assigned to the hygienist. To set up which procedures are hygiene, see Procedure Code(1200). If the appointment does not have a hygienist selected, all procedures get assigned to the dentist.

Note: When using clinics, only providers available for the selected clinic show as options. See User Edit(1109).
- There is a preference in Appointments Module Preferences(608) to always assign the operatory's hygienist as the hygienist, even if it is none.

**Is Hygiene:** Mark the appointment as a hygiene appointment. The appointment color will use hygienist color and the provider time bar will change to hygienist.

**Assistant:** The assistant assigned to the appointment. See the Employees(1233) to add employees.

**Time Locked:** When marked, added procedures will not automatically adjust the appointment time. If you manually adjust the appointment time using the time bar, this box will check automatically.

**Color:** Override the default background color of the appointment. The default color is the provider's appointment color. Click the color box to choose a special color for this appointment only, until it is set complete. Click None to erase a color override.
**Appointment Type**: Assign an appointment type that will determine appointment background color and time pattern. See [Appointment Types](619) to set up options and for time pattern logic. The appointment type's color will override any previously set color (above) and the default provider color. It will remain the override color until another type or color is selected, or until None is clicked to remove the override. Changing an appointment type to none will not remove the appointment type color.

**Time Ask to Arrive**: If you entered an *Ask to Arrive Early* value on the Edit Patient Information window, this field automatically fills each time you schedule an appointment. You can also enter a value manually (00:00 PM). See [Time Ask to Arrive](58) for more information.

**Time Arrived, Time Seated, Time Dismissed**: These values are automated based on time triggers set in Appointment Module Preferences. Usually you will not change them from this window, but instead base values on a confirmed status that will in turn trigger an entry. Confirmed statuses are usually selected in the Appointments module. You can manually change the field values as well, or right-click, then select **Now** to insert the current time.

These confirmed statuses are usually set as the time trigger defaults for each field:
- Time Arrived trigger: Arrived
- Time Seated trigger: In Treatment Room
- Time Dismissed trigger: Front Desk

**Lab**: Attach [Lab Cases](379) to this appointment or edit an existing lab case. This information can show in an appointment view.

**InsPlan1, InsPlan2**: When an appointment is created these fields automatically fill based on the patient's current primary and secondary insurance carrier. Once scheduled, they will update automatically when insurance plans are dropped or added. Once an appointment is set complete, the information will no longer automatically update.
- For large public health clinics, the insurance plan fields allow you to run historical reports once a patient's insurance coverage changed.
- If using version 14.3.36 or earlier, these two fields are only visible if *Public Health* (71) is turned on, and will only update when the appointment is first created.

To change plan information, click [...].

![Select Insurance Plan](image)

The plan options will be limited to other plans entered for the family. To clear a selection click None.

**Req**: Only visible if *Dental Schools* (808) is turned on. Click to attach [Dental School Requirements](1478) to an appointment.

**Appointment Note**: Notes entered here will show in the bubble when you hover over an appointment. This field can also be added to an appointment view.
Right-click to insert the date, a quicknote, or an auto note.

**Appt Fields:** A list of all Appointment FieldDefs(614). Double-click on a field to enter patient information.

**Procedures on this Appointment:** This area lists the patient's treatment planned procedures, along with any completed procedures that have the same date as the appointment. Customize which columns show in Display Fields(900).
- To attach procedures to an appointment, highlight them.
- Click Attach All to quickly highlight all listed procedures with a single click.
- Quick Add List: To the left of the procedure list are commonly used procedure groupings. Simply click on a line item and the associated procedures will be added and highlighted. This is useful when a procedure does not require a tooth number. Customize groupings in Definitions: Appt Procs Quick Add(845).
- Click Add to select a procedure from the Procedure Codes(1195).
- If a procedure on an appointment is marked as complete, then later set back to treatment planned, that procedure will be detached from the original appointment.

To permanently delete a procedure from the list of procedures on this appointment, make sure it is the only highlighted procedure, then click Delete.

**Patient Information:** Shows basic patient information. Can be edited on the Edit Patient Information(62).

**Communications Log:** A log of all scheduling related communications that have been logged (calls, texts, sent eReminder emails, and sent eConfirmation emails) so you can easily see appointments that were rescheduled, canceled, etc. See Commlog(1654). This helps you avoid calling a patient too often when they have indicated a wish to wait. Similarly, if a patient says that nobody called for their recall, you can immediately confirm by reviewing the history. Typically you will not make an entry for appointment confirmations. To edit or view an entry, double-click on it. Set the default commlog type in Definitions: Commlog Types(863).

**Comm:** Enter a log entry in the Communications Log.

**Text:** Send a confirmation text message to the patient. Set the default message in Confirmation Setup(612). This field is only enabled if:
1. On the Edit Patient Information window, a wireless number has been entered for the patient and Yes has been set for Text Messages.
2. Text Messaging has been set up.

**Audit Trail:** View a log of actions that have been taken for this specific appointment. This audit trail is accessible to all users. It is different than the audit trail accessed via the Tools menu.

**To Task List:** Send this appointment to a specific Task List(1705) to keep track of appointments that need follow-up or appointments of a certain type. First you need to create a task list for each purpose. The Object Type of the list should be Appointment.

**Delete:** Delete the appointment.

**OK:** Save changes and close the window.

**Cancel:** Close the window without saving changes.

Note: Changes made to procedures associated to appointments are automatically saved and must be manually reversed.

**Patient Appointments**

In the Appointments Module(1), on the right edge of the window, below the Pinboard, click View Pat Appts.
This window also opens when you schedule an Appointment(20) for a patient who has a planned appointment, a scheduled appointment, a broken appointment, an unscheduled appointment, or a recall due.

**Recall for Family:** All Recall(140) due and scheduled for all family members. Red entries indicate the patient's recall appointment is overdue. Click on a family member to quickly switch to their appointment history.

**Appointment Module Note:** Notes that show in red when you hover over any family member's appointment in the schedule.

**Family Urgent Financial Notes:** Notes entered in the Account Module(150), Family Urgent Financial Notes section. They cannot be edited here. These notes also show in red when you hover over any family member's appointment in the schedule.

**Planned Appt Done:** This box reflects the value of the Done box in the Chart module, Planned Appt tab. When checked, this notifies scheduling that the next appointment will be a recall, not a restorative procedure. If unchecked, there is a planned appointment. See Planned Appointments(325).

**Show Completed Planned Appts:** List planned appointments attached to completed appointments. By default these do not list.

**Appointments for Patient:** The patient's planned, scheduled, broken, unscheduled, and completed appointments.
- The background and text color of appointments can be customized in Definitions: Prog Note Colors(884).
- Double click on an appointment to open the Edit Appointment window.
- Planned appointments have no date or time. To schedule a planned appointment, click Copy to Pinboard.

The buttons along the bottom can be used to quickly take action on an appointment:

**Go to Appt Date:** Quickly jump to the date of the selected appointment.

**Copy to Pinboard:** Copy the selected appointment to the Pinboard(14) for scheduling. Completed appointments cannot be copied.

**Entire Family:** Quickly schedule recall appointments for all family members. For each patient, an appointment with the necessary procedures will be sent to the pinboard.

**Schedule Recall:** For the selected patient only, send a recall appointment, with the necessary procedures, to the pinboard. If a recall appointment is already scheduled, you will receive a message. If patient has an unscheduled recall
appointment, and you schedule a new recall appointment with the same procedures, the procedures will be duplicated in the Treatment Plan(283).

**Note for Patient**: A patient note that can be placed on the schedule. On the Edit Appointment(20) window, enter notes in the lower left, change any other settings, then click OK to send to the pinboard to place on the schedule like an appointment. These notes can be set complete, but cannot be broken or sent to unscheduled list. The default background color is set in Definitions: Appointment Colors(843).

**Create New Appt**: Open the Edit Appointment window to schedule a new appointment.

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**Appointment Lists**

In the Appointments Module(1), at the upper right, above the calendar, click the appointment list icon.

![Appointment Lists](image)

The appointment lists can be used to manage, schedule, and track appointments.

**Recall List(27)**: A list of patients who are due for a recall appointment that is not yet scheduled. Use the list to schedule appointments and send reminders.

**Confirmation List(35)**: A list of all patients who have an upcoming appointment. Use the list to confirm appointments and track confirmation status.

**Planned Appointment Tracker(39)**: A list of every patient who has planned treatment (Planned Appointments(325)) that has not been scheduled. Use the list to schedule planned appointments and track appointment status.
for treatment should be based on a planned appointment so that any rescheduling, broken, or deleted appointments are not lost. This list should be long and regularly reviewed. It should not include recall appointments.

**Unscheduled List** (41): A short list of patients who were no-shows or cancelled without rescheduling. Send appointments here as a quick reminder to contact the patient to reschedule. Appointments should not stay on this list long. The list should not include recall appointments.

**ASAP List** (43): A list of patients who would like to come in as soon as an opening is available. Use the list to identify patients and notify them about openings. Scheduled appointments, planned appointments, and unscheduled recall appointments can all be marked as ASAP.

**EHR Radiology Order List** (458): For EHR only. A list of the logged-on provider's upcoming x-ray procedures that have not yet been approved (marked *is CPOE*). Use the list to quickly approve radiology orders.

Note: These procedures count towards the denominator of the CPOE Radiology Order measure and must be approved by the EHR provider to count in the numerator.

**Insurance Verification List** (49): A list of patients who have upcoming appointments and need their patient eligibility and insurance plan benefits verified. Use it to track and manage verification. Useful for offices that verify insurance prior to upcoming appointments.

## Recall List

Use the Recall List to send and track recall appointment reminders.

In the **Appointment Lists** (26), click Recall.

![Recall List](image)

Every active patient appears in the recall list for the default recall types. Once a patient has recall procedures completed, the patient's next recall due date is calculated and the list can be filtered by due date. Select patients in the list to send an email or postcard reminder. Use the listed preferred recall contact method and recall notes to determine how a patient is to be reminded. When a patient has been sent a reminder, they will disappear from the list for a specified number of days. If the patient does not schedule an appointment, they are put back in the list and for another reminder. The list tracks how
many reminders have been sent and can be filtered by reminder number. Also use the list to schedule recall appointments from phone reminders.

Also see:
- Recall List - Reminders(33)
- Recall List - Reactivations(33)

**Setup**
First, set up the items below before scheduling recall appointments.

Providers(1252): Add providers and hygienists.

Operatories(628): Create operatories and assign the default providers. When using Web Sched, designate Web Sched operatories.

Schedule Setup(1099): Create each provider's schedule and assign to an operatory. Their schedules should extend as far into the future as appointments are to be scheduled. For example, recall appointments 6 months in the future cannot be scheduled if there is no provider schedule set 6 months out.

Web Sched Recall: (optional) Sign up for the eService to automatically send text and email reminders to patients. Patients can click a link in these reminders to schedule their recall appointment online.

Next, set up the Recall Types(635). The default recall types are Prophy, Child Prophy, and Perio. Edit the recall interval or recall procedures for the existing types or add new ones.

Lastly, Setup Recall(632) list defaults to determine which recall types appear in the recall list, the reminder intervals, and the reminder messages.

**Recalls Tab**
List of patients who are due for a recall but are not yet scheduled. Change the list View criteria then click Refresh List to expand or limit the list results.

- **From/To**: The due date range. Set the default values in Setup Recall. No start date will include patients that have never had a recall procedure set complete.
- **Show Reminders**: Only list patients with a specific number of reminders.
- **Recall Type**: Only show patients with specific recall type. Select from Perio, Prophy, or All.
- **Sort**: Sort the list by due date, alphabetically, or by billing type.
- **Provider**: Only view patients for a specific provider.
- **Clinic**: Filter by Clinics(1505).
- **Site**: Filter by Site(1272). Only visible when Public Health(71) is enabled.
- **Group Families**: Group members within a family together (does not affect Web Sched reminders). When checked, and all family members are selected, only one reminder will be sent per family, using the multiple patients in one family message template in Setup Recall.
- **Show Conflicting Types**: Only show patients whose recall type conflicts with the procedures on a scheduled recall appointment. For example, it will show prophy patients who have a scheduled appointment with perio procedures. Only applies to perio and prophy recalls. To show, the scheduled appointment must have all procedures associated with the conflicting recall type (e.g. a scheduled perio appointment must have all Procedures on Appointment for the perio recall type). See Recall Types(635).
- **Included Reminded**: Show patients that have already received reminders, and would otherwise be filtered out according to rules from Setup Recall(632).

The interactive Recall List grid, shows patients due for a recall and their recall information. Customize which columns show in Display Fields(900), Recall List.

- **Due Date**: The date the recall type is due. If blank, the patient has never had a recall procedure set complete.
- **Patient**: Name of the patient with the recall due.
- **Age**: Patient's age.
- **Type**: Recall type due.
- **Interval**: The length of time between each recall appointment for the recall type.
- **#Remind**: The number of reminders sent since the patient's last recall appointment.
- **LastRemind**: The date the last reminder was sent.
- **Contact**: Patient's Preferred Recall Method (set in the Edit Patient Information(62) window). Override the preferred recall contact method with the Use email if setting in Setup Recall. Contact abbreviations: Mail = mail postcard, Hm =
home phone, Wk = work phone, Cell = wireless, Email address = email, SeeNotes = see notes (commlog or recall note),
Text = text message.

- **Status**: Use to track recall communication about a patient's unscheduled recall appointment. To change the status, highlight one or more patients then select a status from the **Set Status** dropdown and click **Set**. Status can also be changed by double-clicking the patient from the list or double-clicking the Recall (140) grid in the Family Module (59). Status options can be customized in Definitions: Recall / Unsched Status (887).

- **Note**: Administrative note specific to recall list. Entries are deleted every time Recall resets.

- **WebSched**: The progress of a reminder sent using the Web Sched button. Progress status: Blank = no web sched recall reminder has been sent, Sending = reminder is being sent, Send Failed = web sched reminder failed to send (double-click to view error details).

Double-click a patient in the list to open the **Edit Recall** (140) window and edit the patient's recall information. Also, right-click a patient to select the patient and go to the Family module or Account Module (150). When one family member is highlighted, all other family members in the list will highlight in red text.

**Options**

- **Postcard Preview**: Preview postcards to send to the selected patients. See Mail Reminders below for more information.

- **Undo**: Undo the last batch of recalls. This is useful when patients were accidentally marked as contacted or the reminders failed to send. The following window will open. Confirm the date to undo recall. Recall notes, statuses, and commlogs will be removed from patient accounts.

  Note: This button is only available to users with "Security Admin" Permission (1119).

**Recall List Undo**

It would be very rare to need to use this tool. It can be used when a new user accidentally verifies that the recall batch printed even though it did not. An admin may pick a date, and then all commlog entries of the recall type will be deleted for that date, causing those patients to once again show on the recall list.

- **Date**: 10/15/2018
- **Patients Affected**: 4

- **Cancel**: Cancel the undo action.

- **OK**: Confirm the undo action and remove the recall.

**Single Labels**: Print a single address label for each selected patient to the default printer for Labels - Single. When printed, the recall status will change to Mailed Postcard.

**Label Preview**: Generate and preview a standard sheet of 30 address labels for selected patients. Click Print to print to the default printer for Labels - Sheet. When printed, the recall status will change to Mailed Postcard.

**E-Mail**: Email the selected patients. See Email Reminders below for more information.

**Print List**: Print the entire Reactivation List.

**Go to Family**: Select a patient and go to the Family Module.

**Go to Account**: Select a patient and go to the Account Module.

**Comm**: Create a commlog for each selected patient.

**Sched Patient**: Schedule the selected patient.

**Sched Family**: Schedule all related family members.

**Web Sched**: When using Web Sched Recall, click to send recall reminders. See Send Web Sched Recall Reminders below for more information.

**Send Web Sched Recall Reminders**
When signed up for Web Sched Recall, email and/or text reminders can be sent with a link for the patient to schedule their appointment online from the Recall List. See [Web Sched Recall](1600) to set up Web Sched Recall.

**Note:** An audit trail entry is made when Web Sched Recalls are sent manually.

1. Select patients to send a recall reminder. If no patients are manually selected, patients with email or text message as their *Preferred Recall Method* (set in the Edit Patient Information window) are automatically selected.
2. Click Web Sched.
3. Click OK on the confirmation message to send the recall reminders to the [Authorized Representatives](1579) of the selected patients. When multiple family members are sent a web sched recall reminder, the message will be aggregated into one and a commlog will be generated for each patient.

See [Web Sched Recall: What Patient Sees](1604).

**Email Reminders**

Manually email recall reminders from the recall list. Regular email and text messaging are not secure methods of sending PHI. See [Encryption of Data at Rest and in Transit](#).

1. Select an email address to use for sending email in the **Email From** dropdown menu. The default is Practice/Clinic set in **Email Setup** (747) (for a single practice) or **Clinic List** (1223) (for clinics). If there is no clinic email, the practice default is used.
2. Select patients to send a recall reminder. If no patients are manually selected, patients with email as their *Preferred Recall Method* (set in the Edit Patient Information window) are automatically selected.
3. Click Email. If you selected no patients, Open Dental will auto-select all patients who have email as their preferred Recall Method.
4. Click OK on the confirmation message to send the recall reminders to the selected patients. If Group Families is checked, the guarantor email is used.

The patient is temporarily removed from the list, recall status is updated to the default email status set in Setup Recall, a commlog is created, and the email reminder is recorded in each patients account. The [Recall](140) grid in the Family module will be updated with the recall status, and notes if added.

**Phone Reminders**

For patients that prefer recall reminders by phone, contact the patient using the phone number listed.

1. To schedule the patient, highlight them from the list and select **Sched Patient** or **Sched Family** (to schedule all family members due). Recall appointments will be created, with recall procedures attached, and placed on the pinboard to be moved to an operatory on the schedule. The calendar will not jump to the recall due date, so remember the appointment due date to locate it on the schedule.
2. If no appointment is scheduled, highlight the patient from the list and select a recall status from the Set Status dropdown that corresponds with the result of the phone call, then click Set.
3. The [Communication Item](1654) window will open with the status and default to commlog type Recall and mode Phone. Edit the commlog to add any details about the phone call that need documented.
4. If needed, double-click the patient to open the [Edit Recall](140) window to add the recall appointment to the [ASAP List](43), add a recall note, disable the recall type for the patient, or change the recall interval.

If the patient scheduled, they are removed from the recall list until due for their next appointment. If the patient did not schedule, they are temporarily removed from the list after the commlog is completed. To keep the patient in the list, change the commlog type to something other than Recall. The [Recall](140) grid in the Family module will be updated with the recall status, scheduled appointment date, and notes if added.

**Mail Reminders**

For patients that prefer mailed recall reminders, print postcards to mail or create a recall report and do a letter merge to mail recall letters.
To create print postcard reminders:
1. Check Group Families (prints one postcard with the entire families recall information).
2. Select patients to create a postcard for. If no patients are manually selected, every patient who does not have a Preferred Recall Method set, or whose Preferred Recall Method is Mail (set in the Edit Patient Information window) are automatically selected.
3. Click Postcard Preview. A preview of the postcards for all selected patients is generated.
4. Click Print to send the postcards to the Default Printer (601) for postcards.
5. If the postcards printed successfully, click OK on the next prompt to finish, otherwise click cancel to start over.

The patient is temporarily removed from the list, recall status is updated to the default mail status set in Setup Recall, and a commlog with type Recall and mode Mail is add to each patients account. The Recall (140) grid in the Family module will be updated with the recall status.

We have found FormSource to have good service and reliability. See their Open Dental Health Care Form Price List.

To create a recall report for a letter merge:
1. Click Run Report.
2. Highlight the fields to include in the report, click OK. 
3. The User Query(1382) window will open with the report results. 
4. Click Export and choose a destination to save the file. 
5. Once saved, complete the Letter Merge(1684).

Troubleshooting
When trying to send Web Sched Recall emails, I receive a message that emails can't be sent because there are no available time slots.

Verify that all setup options for Web Sched Recall are complete and accurate. Does the provider's schedule extend far enough into the future? Are operators correctly marked Is Web Sched?

Why might a patient not show in the recall list?
- Patient already has a recall appointment scheduled.
- Patient has already received a reminder. All commlog entries with a type of 'Recall' are considered reminders.
- It has not been long enough since their last reminder.
- The date range does not go back far enough. Leave the start date blank to include patients who have never had a prophy or perio exam.
- The patient may be listed but not sorted as you expect. For example, when grouped by family patients are sorted by the last name of guarantor, with associated family members underneath.
- Check that the correct recall types are set to show up in the recall list. See Recall List Setup.
- Patient status must be 'Patient'.
- The patient's recall has been disabled.
- (rare issue) Patient has an appointment that was never marked complete so it is considered scheduled. Check their progress notes to locate it.
Recall List - Recently Contacted

The Recently Contacted list in Recall is a list of patients that have received a recall reminder.

In the Recall List(27), select the Recently Contacted tab.

Change the list View criteria then click Refresh List to expand or limit the list results.
- From/To: Select a date range to view patients who were sent a recall reminder between these dates.
- Clinic: Select the clinic(s) to view patients from these clinics that were sent a recall reminder.

The Reminder List grid lists the patients recently contacted and information about their recall.
- Date Time Sent: The date and time the recall reminder was sent.
- Patient: The last name, first name of the patient the reminder was sent to.
- Reminder Type: The reminder method (e.g. email, mail, phone).
- Age: Age of the patient the reminder was sent to.

The following fields are only updated when a Web Sched reminder is sent.
- Due Date: Date the patient's recall is due.
- Recall Type: The recall type the patient is due for.
- Recall Status: Recall status set from the Set Status dropdown or from the recall method.

Right-click on a patient in the grid to quickly view them in the Account or Family modules.

Recall List - Reactivations

The reactivation list is used to track contact attempts for inactive patients.

In the Recall List(27), select the Reactivations tab.
To show the Reactivation List, you must first do the following:

- Enable Reactivation in Show Features (806).
- Create a REACT commlog type in Definitions: Commlog Types (863).
- Set your preferred statuses in Setup Reactivation (631).

**View**

These settings determine how to filter the list.

- **Group Families**: Group family members together on the list.
- **Show "Do Not Contact"**: Show patients who are marked as Do Not Contact.
- **Exclude "Inactive"**: Filter out any patients who are marked with the Inactive status.
- **Show Reactivate**: Select number of contact attempts.
- **Date Since**: Enter the date since last seen. Returns a list of patients who were last seen before the date entered and have not had a completed procedure since.
- **Date Stop**: Enter date before which unseen patients will not be included in reactivation list. Must be a date prior to Date Since. Together these settings creates a range of potential patients to consider. Useful for offices with long histories and don't want to sift through patients that have not been in for many years.

**Sort**

- Last Contacted
- Billing Type
- Alphabetical

**Billing Type**: Filter by patients billing type.

- **Provider**: Patients primary provider.
- **Clinic**: Filter for the selected clinic.
- **Site**: Filter for the selected site.

Click Refresh List for filters to take affect.

**Set Status**: Set the status for all selected patients.

**Email From**: Select the email address to send from.

**Reactivation List**

Patients must meet the following to show:

- Patient must have had at least one completed procedure in the past.
- Patient cannot have any future scheduled appointments.
- Patient has not been contacted (REACT commlog type) within the time period set on the Reactivation Settings.
- Patient has not been contacted (REACT commlog type) more than the maximum number of allowed attempts as set in the Reactivation Settings.
- Patient has not been marked as "Do Not Contact"
Right-click on a patient to see the Family Module or Account Module.

Double-click on a patient to view reactivation information.

![Edit Reactivation](image)

**Status**: Manually change reactivation status.

**Do Not Contact**: Check this box to mark patient as *Do Not Contact*.

**Administrative Note**: Any notes pertaining to the patient that may be useful for office staff.

From the main Reactivation List, highlight the patients you wish to contact, then select from the options below.

**Options**

- **Postcard Preview**: Preview postcards to send to the selected patients.
- **Single Labels**: Print a single label for each selected patient to the default printer for Labels - Single.
- **Label Preview**: Generate and preview a standard sheet of 30 labels for selected patients. Click Print to print to the default printer for Labels - Sheet.
- **E-Mail**: Email the selected patients.
- **Print List**: Print the entire Reactivation List.
- **Go to Family**: Select a patient and go to the Family Module.
- **Go to Account**: Select a patient and go to the Account Module.
- **Comm**: Create a commlog for each selected patient.
- **Sched Patient**: Schedule the selected patient.
- **Sched Family**: Schedule all related family members.

**Confirmation List**

In [Appointment Lists](#), click **Confirmations**.
The Confirmation List is a way to manually manage reminders and confirmations of scheduled Appointments(1). Track communication with patients, send batch emails, postcards, and text messages. To customize confirmation message text and appointment status options, Confirmation Setup(612).

Note: Use eReminders and eConfirmations Feature to automate the process for sending reminders and confirmations about scheduled appointments. These eServices send automated text or email messages to remind patients about upcoming appointments. With eConfirmations, patients can also electronically confirm the appointment, which changes their appointment confirmation status automatically. Additional setup is required.

All patients who meet the view filter criteria will list. You can browse to other windows while the Confirmation List is open.

View: Change the filter criteria. Select view options, then click Refresh (bottom of window) to update results.
- Status: Filter by Confirmation Status(17).
- Confirm List: Select which appointments show:
  - All: Include all appointments.
  - Recall Only: Only include recall appointments (patient has at least one completed procedure and a scheduled appointment with a procedure marked Is Hygiene Procedure).
  - Exclude Recall: Don't include recall appointments (patient has no completed procedures and/or no hygiene procedures).
  - Hygiene Prescheduled: Only include appointments created more than two months before the Scheduled date. Find the appointment creation date using the audit trail on the Edit Appointment window.
- From/To Date: The date range of the list. It defaults to the next two business days.
- Provider: Filter patients by provider.
- Clinic: If using Clinics(1505), filter by clinic.

Set Status: Change the confirmation status of selected appointments. First select the appointment (s), then select a Set Status option. The option is grayed out if the user does not have the ApptConfirmStatusEdit security permission.
**Email From**: Select the *from* email when emailing confirmations. See Email Confirmations below.

**Confirmation List Grid**:
- When one family member is highlighted, all other family members will highlight in red text.
- To edit a patient's appointment, double click a row.
- Right-click options:
  - Select Patient: Select the patient only.
  - See Chart: Select the patient and open the Chart module.
  - Send to Pinboard: Select the patient, open the Appointments module, and place the appointment on the pinboard to reschedule.

**Column definitions**:
- **Contact**: Details for the confirmation contact method. Typically this matches the patient's Preferred Confirm Method ([Edit Patient Information](62)). Mail = Mail, Hm = HmPhone, Wk = WkPhone, Cell = Wireless, Email address = Email, SeeNotes = See Notes, Text = Text Message.
- **Status**: The Confirmation Status(17). Use to track communication with the patient. Customize options in Definitions, Appt Confirmed. This status affects the color of the confirmation circle in the appointment schedule.

**Manage Confirmations by Phone**
Here are a few tips if you are calling patients to confirm upcoming appointments.
- A phone number shows in the Contact column when the preferred confirmation method for a patient is None, HmPhone, WkPhone, or Wireless and a corresponding phone number has been entered.
- Manually change confirmation status using the Set Status dropdown.
- **Commlog** (1654) entries should be made for every phone call so that you have a record of every attempt to contact the patient.
- If a patient needs to reschedule, right click on the appointment, then click Send to Pinboard.
- Click Print List to print the patient information exactly as it currently shows in the Confirmation List.

**Send Text Message Confirmations**
Guidelines:
- Sign up for Integrated Texting Feature.
- Patients must have a wireless phone number and be set to accept text messages (Edit Patient Information window, Text OK).
- We recommend setting the preferred Confirm Method to TextMessage.
- Customize text messages in Confirmation Setup(612).
- Text messaging is not a secure method of sending PHI. See Encryption of Data at Rest and in Transit.

To send text message confirmations:
1. Select the patients to text, or select no patients to let Open Dental auto-select patients.
2. Click Text. If you selected no patients, Open Dental will auto-select patients who have Text as their Contact method, as long as the current status doesn't match the **Status for text messaged confirmation** set in Confirmation List Setup (e.g. Texted).
3. A confirmation message will show. Click Yes to send a text message to selected patients.

The status for each appointment will change to the **status for text messaged confirmation** set in Confirmation List Setup and a commlog will be generated for each text message sent: "Text message sent: [message]"

**Email Confirmations**
Guidelines:
- Patients (or guarantor) must have an email address entered.
- We recommend setting the Preferred Confirm Method to Email.
- Customize the email message in Confirmation List Setup.
- Regular email is not a secure method of sending PHI. See Encryption of Data at Rest and in Transit.
To send email confirmations:

1. **Email From**: In the upper right select the from email. The default is Practice/Clinic.
   - If a single practice, Practice/Clinic refers to the default email set in **Email Setup** (747).
   - If using clinics, Practice/Clinic refers to the email address of the patient's clinic (**Clinic List** (1223)). If there is no clinic email, the practice default is used.

2. Select the patients to email, or select no patients to let Open Dental auto-select patients.

3. Click E-Mail. If you selected no patients, Open Dental will auto-select all patients who have email as their Contact method.

4. A confirmation message will appear. Click OK to create and send email confirmations for all selected patients.

The status for each appointment will change to the **status for emailed confirmation** set in Confirmation List Setup.

**Print Postcards**

Define postcard layout in **Setup Recall** (632) (number of card per sheet, offsets). Customize message text in Confirmation List Setup.

1. Select specific patient appointments then click **Postcard Preview** OR click **Postcard Preview** without selecting patient appointments. Every patient with Mail or HmPhone as their Contact method will be selected and a preview of each postcard will generate.

2. Click Print to send the postcards to the **Default Printer** (601) for postcards. A commlog is automatically generated for each patient with a note of:
   "Confirmation postcard printed for [Name and Address]"

---

**All Smiles**

5216 S Welcome Way
Happy Valley, OR 95118
(351)699-3514

We would like to confirm your appointment on 07/25/2013 at 12:10 PM

Carol Johnson
123 Cedar St
Salem, OR 98777

For postcards, we have found FormSource to have good service and reliability. See their **Open Dental Health Care Form Price List**.

**Print Labels**

Address **Labels** (1708) can be printed on a standard sheet of 30.

1. Select patients then click Label Preview to generate for selected patients only, or click Label Preview without selecting patients to select all patients.

2. Click Print to print to the default printer for Labels - Sheet.

**Confirmation Reports**

You can create a customized confirmation report and send the data to a simple text file. From there, you can merge it with any Word template to print your own customized postcards, letters, etc.

1. Click Run Report.
2. Highlight the fields to include in the report, then click OK.
3. On the User Query(1382), click Export and save the file to another location.

Planned Appointment Tracker

In Appointment Lists(26), click Planned Tracker.
The Planned Appointment Tracker lists Planned Appointments(325) that have been created but not scheduled. If a patient does not schedule a planned appointment, or if the scheduled appointment is deleted, this system will track the appointment so they don't slip through the cracks. This tool is useful for keeping your production levels as high as possible. Regularly review this list to fill your schedule with quality procedures.

To make this process work, every patient who needs treatment of any kind must have a planned appointment created before they leave the office.

Note: This feature is not for scheduling recall appointments. For that, use the Recall List(27).

**Setup:** Click to define default date range of planned appointments to display.

- **Days Past:** Number used to determine *From* date.
• **Days Future**: Number used to determine To date.

Narrow or sort the list by specific criteria. Click Refresh to update.

• **Order by**: Sort the list alphabetically by appointment unscheduled status, alphabetically by last name, first name, or by date the planned appointment was created.
• **Provider**: Only view appointments for a specific Provider(1252).
• **Clinic**: Only view appointments for a specific Clinic(1505).
• **Site**: Only view appointments for a specific Site(1272).
• **Code Range**: Only view planned appointments for specific procedures. Enter a single procedure code or range of codes.
• **From / To**: Click the down arrow to select a specific date range from a calendar. Click the down arrow again to close the calendar. Defaults to today’s date.

To change the active patient, right click on a patient, then click Select Patient.

To jump to a patient’s chart, right click on the patient, then click See Chart.

**Print List**: Print the list as it appears on-screen.

**Schedule a Planned Appointment**
Option 1: Right click the appointment, click Send to Pinboard, then schedule the appointment.

Option 2: Double click the appointment to open the **Edit Appointment**(20). Make **Commlog**(1654) notes as needed. Click Pinboard, then schedule the appointment.

Once scheduled, planned appointments no longer list in the tracker. They will still list in the Chart module, Planned Appts tab until they are marked done or deleted.

**Unscheduled List**
The Unscheduled List is a place to temporarily store Appointments that need follow-up (e.g. no-shows, canceled appointments).

In **Appointment Lists**(26), click Unscheduled.
Webinar: Managing the Unscheduled List.

There are a few ways to send an scheduled appointment to the Unscheduled List.

- In the Appointments Module schedule, right click on the appointment, then select Send to Unscheduled List. Or single click on the appointment, then click the Unscheduled List action button on the right.

- On Edit Appointment, select UnschedList as the Status.

Note: Do not send appointments that have planned appointments to the Unscheduled List. Instead, simply delete the scheduled appointment, then use the Planned Appointment Tracker to track and reschedule.

- An option to prevent Recall appointments from being sent to the unscheduled list can be found in Appointments Module Preferences.

- If Appointments Require Procedures is checked in the Appointment Module Preferences, then unscheduled appointments will be deleted automatically if the attached procedures are scheduled onto a new appointment.

- Completed appointments with procedures attached cannot be sent to the unscheduled list if Prevent changes to completed appointment with completed procedures is enabled in Appointment Module Preferences.

The Unscheduled List is non-modal; you can browse to other windows while it is open.
Narrow or sort the unscheduled list by specific criteria. Click **Refresh** to update.

- **Order by**: Sort the list alphabetically by appointment status, alphabetically by last name, first name, or by date the appointment was created.
- **Include Broken Appointments**: Include appointments that have been marked broken, but have not yet been sent to the Unscheduled List (not recommended). See [Break Appointment](55).
- **Provider**: Only view appointments for a specific provider.
- **Clinic**: Only view appointments for a specific clinic. Only visible when [Clinics](1505) is turned on.
- **Site**: Only view appointments for a specific [Site](1272).
- **Code Range**: Only view unscheduled appointments for specific procedures. Enter a single procedure code or range of codes.
- **From / To**: Click the down arrow to select a specific date range from a calendar. Click the down arrow again to close the calendar. To set a default date range, click Setup (see below).

To change the active patient, right click a patient, then click Select Patient.

To jump to a patient's chart, right click on the patient, then select See Chart.

**Print List**: Print the list as it appears on-screen.

**Setup**: Change default report dates.

![Unscheduled Setup](image)

**Days Past**: Determines the default Start Date. Leave blank to show all.

**Days Future**: Determines the default End Date. Leave blank to show all.

**Reschedule an Appointment**

Option 1: Right click on the appointment, then select Send to Pinboard. Drag the appointment to the schedule.

Option 2: Double click on the appointment to open the Edit Appointment window. Make commlog notes as needed. Click Pinboard then drag it to the schedule.

Once rescheduled, the appointment no longer shows in the Unscheduled List.

**ASAP List**

The ASAP list shows patients who would like to be contacted when an earlier appointment becomes available.

In [Appointment Lists](26), click ASAP.
Use the list to identify patients and quickly notify them about available openings. Appointments can also be scheduled from here.

Note: Sign up for these eServices to easily send and manage ASAP notifications:
- **Web Sched ASAP**: Send ASAP messages about available openings and allow patient to reschedule online.
- **Integrated Texting Feature**: Send text messages about ASAP openings.

Double-click an appointment to view appointment details. The ASAP List can remain open while you open other areas of Open Dental. Right-click an appointment to view quick options:
- **Select Patient**: Open the patient's record with the current module active.
- **See Chart**: Open the patient's record with the Chart module active.
- **Send to Pinboard**: Send the appointment to the pinboard for scheduling.
- **Remove from ASAP**: Remove the appointment's ASAP status, thus removing it from the ASAP List.

To narrow results on the Appointments or Recalls tab, select other filter criteria then click **Refresh** to update.
- **Provider**: Only view appointments for a specific Provider (1252).
- **Clinic**: Only view appointments for a specific Clinic (1505).
- **Site**: Only view appointments for a specific site. See Site List (1272).
- **Code Range**: Only view appointments with specified procedures codes attached.

**Appointments tab**: Lists scheduled, unscheduled, planned, and broken appointments that have been marked ASAP.
- **Appointment status**: Only view appointments with selected appointment status.

**Recalls tab**: Lists all patients with a recall marked Schedule ASAP on the Edit Recall (140) window, even if they have received a recall reminder already.
- **Start / End Date**: Determines which appointments list based on recall due date. Defaults to the current week.
- **Group Families**: Group members within a family together. Defaults to the setting in Setup Recall (632).
Show Reminders: Only list patients with a specific number of recall reminders.

Text: Only available when Integrated Texting is enabled. See Send an ASAP Text Messages below.

Web Sched ASAP Sign up/ Send / History:
- **Sign up:** Sign up for [Web Sched ASAP](#) and/or [Integrated Texting Feature](#). See [eServices Signup](#). Once Web Sched ASAP is turned on, Send/History buttons show instead.
- **Send:** Send is only an option when you access the ASAP List by right clicking on an available time slot in the Appointment schedule and select Text ASAP List. See [Web Sched ASAP](#).
- **History:** View [Web Sched ASAP History](#).

Print List: Print the entire ASAP list as it appears on-screen.

Mark Appointments as ASAP

Scheduled appointments: On the appointment schedule, right click on the appointment then select Mark as ASAP. Or double click the appointment to open the **Edit Appointment** (20) window, then check ASAP.

![Edit Appointment - Tim O'Neil on Wednesday](#)

Status: Scheduled

**ASAP**

Note: To add ASAP to the appointment box or bubble, add ASAP to the **Appointment View** (7).

Appointments on the Unscheduled List (status = UnschedList): From the Unscheduled list, double click to open the Edit Appointment window, then check ASAP.

Planned appointments: Double click a planned appointment to open the **Edit Planned Appointment window** (325), then check ASAP.

![Edit Planned Appointment - Mary O'Neil](#)

**Unscheduled Status**

**ASAP**

Recalls: In the [Family Module](#), [Recall List](#), or [Patient Appointments](#), double click a recall to open the **Edit Recall** (140) window, then check Schedule ASAP.
Reschedule an Appointment from the ASAP List

1. In the ASAP List, right click on the appointment, then click Send to Pinboard.
2. In the Appointments module, drag the appointment from the pinboard to the new time and day.

Note: Rescheduling an appointment using this method will not change its ASAP status. When you schedule a recall appointment this way, the scheduled appointment will not be marked ASAP, however the recall will still be marked Schedule as ASAP.

Send an ASAP Text Message
To enable this option, sign up for Integrated Texting.

1. (Optional) In the ASAP List, highlight the patient(s) to send a text message to.
   Note: If you select patients before clicking Text, only those patients will be texted. If you do not select patients first and click Text, all patients with a wireless number will be auto-selected.
2. Click Text.
3. Enter the date and time of the available appointment, then click OK.
4. Review the text message and modify if needed. The default text message is the Text Manual message. See ASAP Message Setup (47).
5. Click Send. A commlog will be added to each patient's account.

ASAP Message Setup
In the ASAP List (43), at the upper left, click Settings.
On the ASAP List Setup window, you can customize the text and email messages sent to patients about available openings. Messages can be customized per clinic.

**Clinics**: Select the Clinics (1505) the message is for. You can customize messages for each clinic, or use the same message for all or some clinics.
- Default messages: Select Default as the clinic, then customize the messages. To use the default rule for a clinic, select the clinic, then check **Use Defaults**.
- Clinic-specific message: Select the clinic, uncheck **Use Defaults**, then customize the messages.

Double-click a message to edit it.

**Note**: Message types that support HTML formatting will open the HTML Email editor. Raw HTML is not supported for Recall messages.

- **Text Manual**: The default text message when you click Text from the ASAP List.
- **Web Sched Text**: The default message when sending a Web Sched ASAP (1594) text message.
- **Web Sched Email Body**: The default body text when sending a Web Sched ASAP email.

To insert data from the database into the message text, use Template Replacement Tags.
- **[NameF]**: Patient's first name.
- **[Date]**: The date of the available appointment.
- **[Time]**: The start time of the available appointment.
- **[OfficeName]**: The name of the practice or clinic.
- **[OfficePhone]**: The phone number of the practice or clinic.
- **[ASAPURL]**: Add a URL link the patient can click to schedule the appointment (Web Sched ASAP messages only).
- **Web Sched Email Subject**: The default subject when sending a Web Sched ASAP email.

**Maximum number of texts to send to a patient in a day via Web Sched**: Limit the total number of Web Sched text messages that can be sent to a patient per day. Defaults to 2.

Click **Close** to save settings.

Note: Once a patient successfully books an online Web Sched ASAP appointment, you can optionally send them an automated notification of appointment details. See **Web Sched Notify Setup** (1606).

### Insurance Verification List
This is useful for offices that verify Insurance Benefits and patient eligibility prior to appointments.

In the **Appointment Lists** (26), click **Ins Verify**.

Webinar: [Managing the Insurance Verification List](#)
Use the Insurance Verification list to quickly identify when insurance benefits and patient eligibility needs verification. You can also assign ownership of verifications, then track, change, and manage verification status. Set defaults for the list in Insurance Verification Setup (627). The Insurance Verification Security Permission (1118) is required.

The Verification List tab will be highlighted by default. Verifications are grouped by those that are current and those that are past due. Click a tab to view verifications that meet the criteria.

- **Current**: Verifications for appointments in the future that meet the filter criteria.
- **Past Due**: Verifications that meet filter criteria, yet are past due. Typically this list should only include verifications for yesterday's appointments that need to be done as soon as possible. The number of days that determine past due status is set in Insurance Verification Setup (default = 1).

Three types of verifications (Type) may list:

- **Pat**: Patient eligibility needs verification.
- **Ins**: Insurance benefits needs verification.
- **Ins/Pat**: Both patient eligibility and insurance benefits need verification.

Note: There will only be one Ins or Ins/Pat combination row per insurance plan. There can be many patients on a single plan and multiple patients may need to have their eligibility verified which can result in multiple Pat rows per plan. However, the plan benefits only need to be verified once to affect all patients on that plan. To avoid multiple users trying to verify the same plan at the same time, Open Dental only shows one Ins row per plan (or one Ins/Pat row if at least one patient needs to be verified). If a patient is also linked to the plan verification it will be the patient with the closest appointment date and time.

Click on a column header to sort the list in ascending or descending order. To preview insurance plan information, subscriber information, and verification status, highlight a patient or plan. The info will appear at the bottom. To open the Insurance Plan (81), double click a row, or right click and click Go to Patient Plan.

Note: To change information, the Insurance Plan Edit security permission is required.

**Verification Filters**: If needed, change the criteria to change the results. Set defaults in Insurance Verification Setup.

- **Days until scheduled appointment**: The default is 7. Example: patients with scheduled appointments in the next 7 days will list.
- **Plan benefits haven't been verified in**: Determines which insurance plans (Ins) list based on the last benefit verification date. The default is 90 days.
- **Days since patient eligibility**: Determines which patients (Pat) list based on the last patient eligibility verification date. The default is 30 days.
- **Carrier**: Enter a specific carrier name. Blank = all carriers.
- **For User**: List verifications assigned to a specific user. The dropdown list will all users currently assigned a verification. Click to select, or click [...] to select from a pick list. Select All = All Users. Select None = Unassigned.
- **Verify Status**: Only list plans and patients with a specific verification status. Customize options in Definitions: Insurance Verification Status (874).
- **Region** (only visible when using Clinics (1505)): List verifications by clinic region. The options can be customized in Definitions: Regions (889).
- **Clinic** (only visible when using Clinics): List patients with appointments in a specific clinic. Only clinics accessible by the logged-on user are options.

- **Note**: 01/01/0001 will be the initial last verified date for all plans and patients.
- **To exclude a plan from the list, check Don't Verify on the Edit Insurance Plan window.**

---

**Mark a Patient Eligibility (Pat) and/or Insurance Benefits (Ins) as Verified**

There are several ways to mark patient eligibility and/or insurance benefits as verified. Marking a verification as verified will change last verified dates on the Edit Insurance Plan window.
Option 1:
1. On the Verification List tab, right click on a verification then select an option. Options will vary depending on the type of verification selected.

   **Verify Patient Eligibility**: Mark patient eligibility as verified (change the Eligibility Last Verified date to today).

   **Verify Insurance Plan**: Mark insurance benefits as verified (change the Benefits Last Verified date to today).

   **Verify Both**: Mark both patient eligibility and insurance benefits as verified (change both dates today).

   A confirmation message will show.

   ![Confirmation Message](image)

   2. Click OK.

Option 2:
1. On the Verification List tab, highlight the verification row. General insurance plan and subscriber information will show in the bottom of the window.

2. Click one of the verified buttons:
   - **Mark Patient Eligibility Verified**: Mark patient eligibility as verified (change the Eligibility Last Verified date to today).
   - **Mark Ins Benefits Verified**: Mark insurance benefits as verified (change the Benefits Last Verified date to today).

3. A confirmation message will show. Click OK to confirm.

Option 3:
1. On the Verification List tab, double click a verification row, or right click and select Go To Plan to open the Edit Insurance Plan window.

2. To verify patient eligibility, enter a value for Eligibility Last Verified.

3. To verify insurance plan benefits, enter a value for Benefits Last Verified.

4. Click OK to save.

**Change Verification Status**

Verification status is a way to track insurance verification progress. Status options are defined in Definitions, Insurance Verification Status. When you change a status, the status date will update to reflect the date of the change.

Option 1:
1. On the Verification List tab or Assign Verification tab, right click on a patient or plan, select Set Verify Status to, then select the option.
2. (optional) Enter a note.
3. Click OK.

Option 2:
1. On the Verification List tab, highlight the patient or plan. The insurance plan, subscriber, and status will show at the bottom of the window.
2. Click the Verify Status dropdown and select an option.
3. (optional) Enter a note.
4. Click OK.

**Assign Ownership of Verifications**

This tool is useful for delegating responsibility for verifications to specific users. Multiple plans and patients can be assigned at once. To be assigned a verification, a user must have the *Insurance Plan Verification List* security permission.

Option 1: On the Verification List tab, right click on a verification, click Assign to User, then select the user.

Option 2: Useful when assigning many verifications at once.

1. Click the Assign Verification tab.
By default, Unassigned verifications list (For User).

2. Highlight the verifications to assign. To select many, click and drag, or press Ctrl or Shift while clicking.
3. Right click anywhere on a highlighted verification, select Assign to User, then select the user, or, under Assign Verification, click [...] next to To User.

Double click the user to select, then click Assign. Select None = Unassigned.
Update Provs on Future Appts

In Operatories(628), click Update All.

The Update Prov on Future Appts tool changes the provider, hygienist, and clinics (if applicable) on all future appointments in an operator to match the operator's scheduled provider and hygienist. This is useful when you change an operator's provider or hygienist or after a final conversion (replaces the hygiene query).

Run the Tool

For each operatory, make sure the operatory provider and hygienist are set correctly. See Operatories(628).

If using schedules, ensure the provider is assigned to the correct operatories under Setup, Schedules.

Click Yes to start running the tool.

A Done message will indicate when the tool is finished running. Click OK to close.

- Note: If, in Schedule Setup(1099), a provider's time block has been assigned an operatory, the scheduled provider will override the operatory provider, if different.
- Running this tool will update the provider and hygienist on every future appointment in the operatory. To only change provider/hygienist on individual appointments, see Edit Appointment Window(20) instead.
- This tool will not remove the Is Hygiene flag from the appointment, even if Is Hying is not checked in the operatory setup.
- This tool will not remove a Hygienist even if the operatory no longer has a Hygienist assigned, or a Hygienist is assigned to the operatory schedule.
- We recommend backing up your data before running the tool.
- The logged-on user must have the Setup and Edit Appointment permissions.
- This tool should be run after hours, as it may take a long time to run.

After a Conversion

After a Final Conversion, future hygiene appointments may have the hygienist assigned as the primary provider. Once providers and operatories are setup, you should update appointment providers to match operatory providers.

Versions 17.1 and later: Run the Update Prov on Future Appts tool for each operatory.

Versions 16.4 and earlier: Contact Open Dental. We will run a query to change these appointments to the dentist and hygienist assigned to the appointment’s operatory.

Set Appointment Complete
In the Appointments Module(1), select the appointment. Click the Set Complete action button.

Alternatively:
- Right click on the appointment. Select Set Complete.
- In the Chart Module(298) Progress Notes, right click the appointment. Click Set Complete.
- In the Procedure(303) Edit window, click Set Complete.

Once a scheduled appointment is finished, you should set it complete. This will mark all procedures attached to the appointment complete as well.

Several preferences affect behavior when setting an appointment complete.
- Appointments Module Preferences(608): Allow setting future appointments complete, Allow setting appointments without procedures complete.
- Chart Module Preferences(706): Allow setting procedures complete, Procedures Prompt for Auto Note.

When an appointment is set complete, the following changes occur:
- The appointment status changes to complete.
- The status of each attached procedure(303) is changed from treatment planned (TP) to complete (C).
- The provider for each procedure is assigned automatically based on the operatory(628) settings.
- Default Procedure Notes(316) are copied into each procedure.
- The procedure date is set to today’s date.
- For advanced users:
  - Sets the SiteNum for each procedure to be the same as patient.SiteNum.
  - Sets appointment InsPlan1 and InsPlan2 according to the current coverage.
  - Syncs recall.

Note: If the appointment provider does not match at least one provider on an attached procedure, the user will receive a prompt.

Manually changing a procedure’s status to complete on the Procedure Info window only changes the status. It does not change the procedure date or copy default procedure notes.

Break Appointment
In the Appointments Module(1), a broken Appointment will display with a big X.

There are three ways to break an appointment:

1. Right-Click to Break
   Right-click the appointment. Select Break Appointment.
2. Break Button
Highlight the appointment. At the right, click the Break button.

3. Manually
Double-click to open the Edit Appointment window. Manually change the Status to Broken.

Tracking Broken Appointments
If using method 2 or 3, the Broken Appt Options window will show. It serves the same purpose as the six separate options on the right-click method.

Missed adds a procedure with code D9986 to the patient’s chart. This is used when the patient simply did not show up for the appointment.

Cancelled adds a procedure with code D9987 to the patient’s chart. This is used when less than 24 hrs notice was given, making it hard to fill the time slot.

Note: You may be missing these procedure codes. If you are in the USA, update to the most recent ADA codes. If you are a foreign customer, you must manually create them.

These two procedure codes are how broken appointments are tracked. You can change this behavior in Appointments Module Preferences (608). The Amount is based on the fee entered for the procedure code.
Depending on how preferences are set up, the Adjustment Edit(203) window or Commlog(1654) might open.

We recommend handling broken appointments before the end of day. Send them to the Unscheduled List(41), reschedule them, or delete them. Otherwise, incomplete appointments may get left in the Appointments module.

Completed appointments cannot be broken if procedures are attached and Prevent changes to completed appointment with completed procedures is enabled in Appointments Module Preferences(608).

- Note: Customize text color of broken appointment procedures in the Account module in Definitions: Account Colors(838).
- To add a broken appointment to the ASAP List(43), mark it as ASAP on the Edit Appointment(20).
- To trigger other automated actions, see Automation(819).
- To generate a report of broken appointments, see Broken Appointments Report(1350) or Graphic Reports(1376).

Delete Appointment

In the Appointments Module(1), select an appointment. Click the Delete Action Button.
Alternatively:
- In the Appointments Module, right-click on the appointment. Select Delete.
- In the Chart Module Progress Notes, right-click the appointment. Select Delete.

Appointments should not be deleted without considering how they will be tracked.
- If the appointment was missed or was cancelled without 24 hrs notice, then use Break Appointment.
- After breaking the appointment, consider sending it to the Unscheduled List for followup.
- If the patient really does not want followup, then make sure the appointment is still in the Planned Appointments list so that it will show in the Planned Appointment Tracker.
- A recall appointment is a little different. You can delete a recall appointment because it will continue to show on the Recall List for followup.
- Completed appointments cannot be deleted if procedures are attached and Prevent changes to completed appointment with completed procedures is enabled in Appointments Module Preferences.

Time Ask to Arrive
In the Appointments Module, double click on a Scheduled Appointment.

In **Time Ask to Arrive**, enter the time you want the patient to arrive in 00:00 format.

Using this method, the early arrival time only affects a single appointment. This can be useful for new patients who need to fill out paperwork prior to the appointment.

- **Note:** The appointment schedule will show the appointment time, not the Time Ask to Arrive.
- To display the Time Ask to Arrive in the appointment box, see Appointment Views.
- The Time Ask to Arrive will display on patient literature (e.g. email, postcard reminders, etc.), and can be included in the eReminders and eConfirmations Feature.
- If an appointment is rescheduled, the Time Ask to Arrive value will reset. If an Ask to Arrive Early value is entered on the Edit Patient Information window, it will be used to calculate a new arrival time, and a message will indicate the previous arrival time.
A patient can be scheduled with a Time Ask to Arrive outside of open office hours without a warning message. For example, the clinic opens at 8:00 am, the patient is scheduled for an 8:00 am appointment but is asked to arrive at 7:45 am (the office is not open).

**Early Arrival Time for all Appointments**

In the patient's [Edit Patient Information](62), enter **Ask To Arrive Early** in the highlighted area.

Using this method, every time an appointment for the patient is scheduled, a popup will notify you of the early arrival time and the Time Ask to Arrive field on the Edit Appointment window will automatically populate with the Ask to Arrive Early value. For example, if a patient is scheduled for a 9:00 AM appointment, the popup will prompt you to ask the patient to arrive at 8:45 AM.

**Ask to Arrive Early:** Enter the length of time, in minutes, you want the patient to arrive early.

**Save for entire family:** Check this box to apply the early arrival time to everyone in the patient's family.

This can be useful for patients who typically arrive late to appointments.
The Family Module is where basic patient and insurance information is entered and organized. Also see Webinars.

**Family Toolbar**

**Family Members**
- **Add**: Add a new patient to the current family and open the [Edit Patient Information Window](#). Use Move to add an existing patient to a family.
- **Delete**: Delete the selected patient. Patient's can only be deleted if no information has been entered (e.g. procedures, perio charts, images, etc).
- **Set Guarantor**: Make the selected patient the guarantor (see below).
- **Move**: Move the selected patient to a new family or to a different existing family.

*Note: A popup will appear warning that Fam Fin Urgent Notes and Family Financial notes will not transfer. Take care to manually copy those over if needed.*

**Clones**: Only visible when [Patient Clones](#) is turned on.
- **Add**: Create a patient clone for the selected patient.
- **Synch**: Synch data between an original and clone patient record.
- **Break**: Break the relationship between a clone and original patient.

**Super Family**: Only visible when [Super Families](#) is turned on.
- **Add**: Create a super family or add a patient to a super family.
- **Remove**: Remove the selected patient from the super family.
- **Disband**: Remove the relationship between all members of the super family.

**Add Insurance**: Attach an insurance plan or view all insurance plans for the family.
- Click the main button to add insurance plan information. See [Add Insurance](#).
- Click the dropdown, then Plans For Family, to view all insurance plans for the family, including dropped plans (see Plans for Family below).
**Discount Plan:** Click the main button to add Discount Plans(1230). Click the dropdown to drop a discount plan.

**Patient Picture**
If an image exists in the designated patient picture folder of the Images Module(480), the most recent picture will show at the top left. See Patient Pictures(142).

**Family Member List**
The current patient is highlighted in red. To select a different family member, click on their name. To open a family member's Edit Patient Information window, double-click their name.

- **Guarantor:** The family member designated as the guarantor appears first in the list and in bold. This person is responsible for the account. It does not need to be a patient (e.g. parent of a minor). The Guarantor cannot be deleted or moved unless he/she is the only family member. Moving the guarantor into another family effectively combines two families, which combines account notes and address/phone notes.
- **Clones:** Patient clones are listed in ALL CAPS.
- **Other Family Members:** Family members can only be deleted when they have no procedures, claims, payments, procedures attached to claims, or commlog entries. Once deleted, you will no longer have access to that patient from any portion of the program.

**Recall**
This area lists all recalls due and scheduled for the patient. The columns that show can be customized in Display Fields(900), FamilyRecallGrid. Double-click anywhere in the Recall area to edit recalls for a patient. See Recall Appointments(140).

**Patient Information**
A summary of patient information. Double-click in the area to edit or enter information on the Edit Patient Information Window(62).

- Customize which fields show here in Display Fields, PatientInformation. See Custom Patient Fields(687) to add or hide definitions in this list.
- To enter Referrals(76), double-click in the Referrals cell. The cell color can be customized in Definitions: Misc Colors(876).
- To enter Payor Types, double-click in the Payor Types cell.

**Patient Clones**
This grid only shows when the selected patient has a patient clone. It lists the original patient and all associated clones.

**Super Family**
This grid only shows when the selected patient is part of a super family. It lists all super family members.

**Insurance Plans**
The Insurance Plans area displays all insurance currently attached to the patient as active coverage. A nearly unlimited amount of plans can be attached (primary, secondary, tertiary, primary medical, secondary medical, etc.). Change the background color of Subscriber information in Definitions, Misc Colors. Double-click onto any plan to edit. Double-click onto the history grid to open Insurance History(136).
Double-click a plan to see more details. Dropped insurance plans never get deleted and are always available here for reference.

**Discount Plans**
This grid shows when a discount plan has been attached to the patient. Double-click on the plan to edit description, fee schedule, or adjustment type, or to drop the discount plan.

**Edit Patient Information**
In the Family Module (59), double-click in the Patient Info area.
Alternatively:

- In the Chart Module (298), double-click in the Patient Info area.
- In the Select Patient (1649) window, click Add Pt to create a new patient account.
- In the Family module, click Add to create new family member.

You can prompt staff to complete certain fields using Required Fields (71) marked with an *. If required fields are incomplete when staff clicks OK on the window, a message will notify them.

Click Cancel to view the incomplete fields, marked by a red exclamation point. Enter the required information. Click OK to save.

**Appointment scheduling is restricted:** If checked, appointments cannot be scheduled for the selected patient. This includes scheduling new appointments, sending existing or planned appointments to the pinboard, moving an
appointment to another time slot, or scheduling an appointment from the unscheduled list. If unchecked, appointment scheduling is not restricted.

- To create automation that automatically checks/unchecks this box based on billing type, see Automation(819).
- To change the setting (manually or via automation), the logged on user must have the Patient Restriction Edit security permission.
- In Display Fields(900), add Pat Restrictions to the Patient Information grid to view scheduling restrictions associated to the selected patient.

**Patient Number:** Assigned automatically by the system and shown for reference. Numbers are assigned sequentially and there is no way to fill in gaps. Gaps can occur when a database split is performed or when patients are deleted. To find out how many patients you have, use a query.

**Names:** All name information is entered in the upper left. For easy reference, the Preferred Name will show before the first name in most areas of Open Dental. The Salutation is not used anywhere, but can be useful for offices that use Letter Merge(1684).

**Status:** The statuses are as follows:
- Patient: This is the default.
- NonPatient: Someone who is not a patient, e.g. the parent of a child, a guarantor, or an insurance subscriber.
- Inactive: Patient who is no longer active. Will still show in Select Patient window and appear in A/R if a balance is due. Will not appear in Recall List(27), Birthday Report(1349), Treatment Finder(1369), or on statements (unless a balance is due).
- Archived: Patient who is not coming back. Will not show in Select Patient window unless Archived/Deceased is checked, so might accidentally end up with a duplicate chart some day. To edit archived patient information, the logged on user must have the Archived Patient Edit permission.
- Deceased: A deceased patient. Will not show in Select Patient window unless Archived/Deceased is checked.
  - Consider zeroing out the account at the same time if you do not wish to collect amounts due.
  - To lock the patient's age as of the deceased date, see Edit Patient Information: EHR Misc Tab(76).
  - If a patient has upcoming appointments scheduled, and they are marked as deceased, you will get a prompt to remove future appointments.
- Prospective: Someone who has never been in before, but might become a patient. This status can be automated in Operatories(628).
- Deleted: A hidden status that the user will never see. The patient will no longer show anywhere in the program and the integrity of the database is maintained. Use the Patient Status Setter(1421) tool to set multiple patients at once to active or inactive.

**Gender:** The biological sex of the patient. Unknown is for HIPAA compliance in case a patient does not wish you to record or track their gender. To record gender identity or sexual orientation, see Edit Patient Information: Public Health Tab(69).

**Position:** Marital status of the patient.

**Family Relationships:** Indicates this patient's family relationship (e.g. guardian, spouse, father, mother) to other patients. See Family Relationships(74). For EHR, this is used when sending immunization data.

**Birthdate/Age:** The patient's birth date. Age will automatically calculate when you leave the field. Birth dates entered on select patient window automatically carry over when adding new patient(s).

**Medicaid ID, State:** This field is only visible when Medicaid is turned on in Show Features(806). If entered here, also enter the number in the insurance plan as the Subscriber ID. Enter the two-letter State Abbreviations(1270) for the Medicaid State. Entering the first letter of the abbreviation will prompt a dropdown of choices beginning with that letter.

**Chart Number:** Optional, but not recommended. Useful when you need a place to enter patient ID numbers if you converted from another program, or if you put numbers on your paper charts. Click Auto to assign the next available numeric chart number to the patient. It will not work for mixed letters and numbers. The only place the chart number will show is in the Family module.

**Ask to Arrive Early:** If a value (in minutes) is entered, a reminder message, with requested arrival time, will appear each time an Appointment is made for this patient. See Time Ask to Arrive(58) for more information. If Same for entire family box is checked, when information in this area changes for one family member, the information changes for all family members. If you create a new family member, this box will not automatically be checked.
**Prefer Contact/Confirm/Recall Methods**: How the patient prefers to be contacted for each action.

- **Contact**: Preferred general contact method. This option will show in bold in the Family module, Patient Information area.
- **Confirm**: Preferred method when confirming appointments. The selected information will list for the patient in the Contact column of the Confirmation List(35).
- **Recall**: Preferred method when scheduling recall appointments. This selected information will list for the patient in the Contact column of the Recall List(27).

There are eight options:

- **DoNotCall**: DoNotCall will show.
- **HmPhone**: Lists the patient's Home Phone number.
- **WkPhone**: Lists the patient's Work Phone number.
- **Wireless**: Lists the patient's Wireless Phone number, preceded by Cell (typically used for calling a wireless number).
- **Email**: Lists patient's email address(es).
- **SeeNotes**: SeeNotes will show.
- **Mail**: Mail will show.
- **TextMessage**: Lists the patient's wireless phone number, preceded by text (used for text messaging which is available from the Confirmation List).

Hints: The preferred method can affect defaults in other areas including:

- When emailing Web Sched Recall reminders (manual and automated).
- When emailing recall reminders or printing recall postcards from the Recall List (text messages can only be sent individually, not via the Recall List).
- When emailing or texting confirmation reminders or printing confirmation postcards from the Confirmation List.
- When sending automated appointment reminders about scheduled appointments. See eReminders.

**Exclude eConfs/eReminders**: Exclude this patient from receiving text and/or email eConfs or eReminders. Select both options to exclude patients from all eConfs and eReminders. Leave blank to include the patient.

- **Text**: Do not send the patient eConfs or eReminders via text message.
- **Email**: Do not email the patient eConfs or eReminders.

*Note*: When left blank, patient will receive eConfs and eReminders based on office rules.

**Trophy Folder**: Only visible when using the enhanced Trophy Bridge.

**Language**: Customize patient language options in Miscellaneous Setup(921).

**Clinic**: If using Clinics, set the patient’s default clinic for patient payments, claim payments, and adjustments. If unassigned, the default will be none. To force users to assign a clinic, see Family Module Preferences, Allow new patients to be added with an unassigned clinic.

**Referred From**: Click [...] to select a referral source. New referrals can be added in the Referral List(1268).

**Specialty**: Select a specialty. Customize options in Definitions: Clinic Specialties(862). Useful to differentiate Clone(145).

**Address and Phone area**: Contains fields that are normally the same for an entire family.

**Same for entire family**: If checked, when information in this area changes for one family member, the information changes for all family members. This box is normally checked. It is not a database field, rather it compares the existing values of all family members and applies any changes to all members so they match. If you uncheck the box, you must make a change for the setting to be saved. When unchecked, changes only apply to the selected patient, and family members will have different values. If, at a later date, you check the box, changes will be applied to all family members.

**Same for entire super family**: Only visible when the patient is the head of a Super Family(143) and Allow syncing patient information to all super family members is checked in Family Module Preferences(637). When checked, address and phone information for the super head will be applied to all super family members (not just guarantors).

**City/State/Zip**: Enter the zip code, and the City and State fields will fill in automatically. To speed up data entry, click the dropdown to select from frequently used zip codes. Or, click Edit Zip to associate cities and states with zip codes and add to them to the master list. See Zip Code List(1273).
Show Map: Open the patient's address in Google Maps. Only shows if Show Google Maps in patient edit option is checked in Family Module Preferences.

Address and Phone Notes: Make notes about when to call a patient, which number the patient prefers, extra phone numbers, extensions, bad phone numbers, bad addresses, alternate addresses, etc. Text will show in bold red in the Patient Information area of the Family module. These notes also show in the Unscheduled List, Recall List, and appointment.

Same for entire family: If checked, when information in this area changes for one family member, the information changes for all family members. We recommend checking notes for other family members before applying to entire family so you don't accidentally overwrite another note.

Billing and Providers: Contains fields that are normally the same for an entire family.

Same for entire family: If checked, when information in this area changes for one family member, the information changes for all family members.

Credit Type: A one letter code that your office can use to track credit worthiness of patients based on credit reports, history of payment, or whatever criteria you prefer. These letters are simply for your information and are not used internally. One method is using A, B, or C. If credit is unknown, you can use a 0. The code displays in appointments when CreditType is added to an appointment view, and in other places throughout the program.

Included in Super Family Billing: Only visible when the patient is a guarantor of a family included in a Super Family. If checked, this patient will show as the patient on super statements (statements that include the account activity for all super family members).

Billing Type: The patient's billing type. Customize options in Definitions: Billing Types(850). To change, user must have the Patient Billing Type Edit security permission.

If the preference in Family Module Preferences for New patient primary insurance plan sets patient billing type is checked, when a new primary insurance plan is created for the patient, and a billing type is set for the plan, the patient's billing type will automatically change to match. (If you change an existing plan's billing type, it will not automatically change the patient's billing type).

Primary Provider: Select the provider who will usually see the patient. The default is the provider set as the practice default. If using clinics and providers are restricted to clinics, only providers available for the patient's assigned clinic are options. To change, user must have the Patient Primary Provider Edit security permission.

Secondary Provider: The patient's secondary provider, often the hygienist. If using clinics and providers are restricted to clinics, only providers available for the patient's assigned clinic are options.

Fee Schedule (rarely used): This is useful if you want to attach a discount (e.g. cash only) fee schedule for this patient. For example, if the patient does not have insurance and is given a 10% discount for paying in cash, create a discount fee schedule (copy your office fees, then reduce the prices 10%), then select that fee schedule here. Procedures will then look at that fee instead of the provider's fees. Usually this selection will be none and the fee schedule will be determined by the provider's default fee schedule, or the insurance plan fee schedule. See Fee Schedule Logic(1209).

Email and Phone: Add contact information for the patient. This information can also be set same for entire family (see above).

Same for entire family: If checked, and you change email or phone information for the patient, the information will also change for all existing family members. If this box is checked for other family members, and you create a new family member, email and phone information is not copied. If you check it when adding a new family member, any changes made will be applied to all other family members.

Wireless/Work Phone: Phone numbers automatically format as you type.

Text OK: Indicate if patient can receive text messages.
- Yes: Patients can receive text messages.
- No: Patient cannot receive text messages.
- ???: By default means No, patients cannot receive text messages. To instead have it mean Yes, see Family Module Preferences, General tab, Text Msg OK status.
**Email Addresses**: The patient's complete and valid email address. To enter multiple addresses, separate each with a comma. At minimum one email address is required in order to enable the Email toolbar button and send emails. See [Email](1656). Note: Email addresses must be valid (e.g. name@email.com) for emails to send. Invalid email addresses will be skipped.

**Tabs**: The following tabs may be available depending on what options are turned on in Show Features.
- **Edit Patient Information: Public Health Tab**: (69) (race, ethnicity, grade level, school, responsible party)
- **Edit Patient Information: Hospitals Tab**: (67) (ward, admit date)
- **Edit Patient Information: Other Tab**: (67) (SSN, date of first visit, student status)
- **Edit Patient Information: Emergency Contact Tab**: (67)
- **Edit Patient Information: EHR Misc Tab**: (76) (mother's maiden names, date deceased)

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**Edit Patient Information: Emergency Contact Tab**

In the [Edit Patient Information](62) window, click the Emergency Contact tab.

![Emergency Contact Tab](image)

**Emergency Name**: The emergency contact's name.

**Emergency Phone**: The emergency contact's phone number.

Emergency contact information will display as *ICE Name* and *ICE Phone* in the *Family Module* (59) Patient Information grid.

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**Edit Patient Information: Hospitals Tab**

In the [Edit Patient Information](62) click the Hospitals tab.

![Hospitals Tab](image)

This tab is only visible when [Hospitals](806) is turned on.

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**Edit Patient Information: Other Tab**

In the [Edit Patient Information](62) window click the Other tab.
SS#: Social Security Number. Dashes are automatically added.

**Date of First Visit**: This field is usually updated automatically based on the first appointment or procedure status.
- If the field is blank (no date of first visit), there are no completed procedures, and a new procedure is created (regardless of status), the date of the new procedure is automatically inserted.
- The date is updated when a procedure is set complete and no other completed procedures exist.
- The date is updated if an appointment date is changed, the appointment is marked as New Patient, and there are no completed procedures yet.

If the date of first visit is manually entered, it will not be updated when an appointment date or procedure status changes. However, the date is always cleared when an appointment marked as New Patient is deleted and there are no completed procedures.

**Student Status if Dependent Over 19 (for Ins)**: Choose a student status for the patient. Used for insurance claims.

**College Name**: Enter the name of the college for the patient. Used for insurance claims.

**Date of First Visit Logic**
Setting the DateFirstVisit on the Patient table, other than directly editing it from FormPatientEdit, is done in the following ways:

Procedures.SetDateFirstVisit method usage scenarios:
1. When any procedure is inserted regardless of status, if no C procs and date blank, changes date. There is a bug in Appointments.AptTypeMissingProcHelper in which the date could be update even if no procedures were inserted. This would occur if you chose an ApptType for an appointment, but all the procedures associated to it were already charted. I am unsure if there is a problem with updating this using the QuickAdd buttons from the ApptEdit window. If you have the ability to make a button that contains no codes then this would also cause an update to the DateFirstVisit.
2. When updating a procedure to status C. If no C procs and date is blank or less than 7 days old, update visit date.
3. When an appointment is deleted. If no C procs and appointment is set to IsNewPatient, clear visit date.
4. When changing an appt date of type IsNewPatient. If no C procs, change visit date to selected date.

Most places set the first visit date to todays date from the server. Here are a few exceptions:
1. FormRepeatChargeEdit Manual add will set the date to todays date based on the local machine (Possible bug)
2. Dropping an appt on the schedule will use the DateSelected of the appointment module
3. Marking a proc complete in the chart module will use the ProcDate of first selected Proc in the list of selected Procs
4. The Appointments.AptTypeMissingProcHelper uses the AptDateTime to set the date
5. The QuickAdd in ApptEdit uses the AptDateTime as well
6. In the HL7 parser, we utilize whatever is set to the ProcDate as the date first visit when we insert new procs
Edit Patient Information: Public Health Tab

In the Edit Patient Information (62) click the Public Health tab.

This tab is only visible when Public Health (71) is turned on.

Race/Ethnicity: If EHR is not turned on, click [...] to open a selection window.
Race and ethnicity options, based on CDCREC codes, list on the right in tree view. Race and ethnicity selections for the patient list on the left.

- Click + to expand a folder; click - to collapse a folder.
- To select an option, highlight it, then click the left arrow.
- To remove a selection, highlight it, then click the right arrow.
- Click OK to save all selections.

If EHR is turned on, Race and Ethnicity are selected using dropdowns instead of a selection window. Click a dropdown, then highlight the options to select. Press Shift while clicking to select multiple race options.

**County**: As you type a name, matching county names will appear in a dropdown for you to select. Counties must already exist in under Lists, **Counties** (1228).

**Site (or Grade School)**: Click [...] to select a site from the master list. Sites have a table in the database, linked by a proper SiteNum key. See **Site List** (1272).

**Grade Level**: Click the dropdown to choose a grade level.
**Treatment Urgency:** Click the dropdown to select a treatment urgency for the patient.

**Responsible Party:** Select the person other than the patient or guarantor, who is the responsible party. This person will have access to the patient's health information in the Patient Portal Feature. This is especially useful in nursing homes.

- Click [...] to select a family member or other patient.
- Click X to remove a selection.

**Sexual Orientation:** Click the dropdown to select the patient's sexual orientation. Options are based on SNOMED CT codes.

**Gender Identity:** Click the dropdown to select the patient's gender identity. Options are based on SNOMED CT Codes(727).

### Public Health

To turn on public health features, select Public Health in Show Features(806). When enabled, the following features are available.

There is an **Edit Patient Information: Public Health Tab**(69).

**Site List**(1272) is enabled.

**Treatment Plan Edit window:** There is a **Responsible Party** field.

**Import 834 Files:** In the Manage module, the Import Ins Plans buttons shows. This is a very specific function for importing 834 files. See Import Ins Plan 834(579).

**Public Health Screening**(1457): Data entry for public health screenings is designed with speed and simplicity in mind. Data can be entered in the classic screening form or a customized form (using sheets).

- When using a custom form, sealant codes marked on permanent teeth automatically add sealant procedures to the patient's chart. See Screening Layout(1176).
- To set up screening groups, set permissions, and perform public health screenings, in the main menu, click **Tools, Public Health Screening**.

**Public Health Reports**

- **UDS Report**(1374)
  - These reports are intended to be saved to text files and sent to a centralized office where it gets loaded into one larger table containing data from many locations.

**Raw Screening Data Report**(1372): All screening data reported as a single table, for a specific date range (classic screening form only).

**Raw Population Data Report**(1373): A list of patients who have had treatment done, for a specific date range.

### Required Fields

Using Required Fields, you can prompt staff to complete certain fields when entering patient information or insurance payments.

In the **Main Menu**(592), click Setup, Required Fields.
Examples:
- Birthdate cannot be blank.
- Gender cannot be unknown.
- Student status must be chosen if patient age is greater than 17 or less than 35.
- Validate the number of digits in a Medicaid ID.

How it works:
- When staff enters patient information, required fields are indicated with an asterisk (*).
- If required fields are incomplete when staff clicks OK, a notification message will show with two options: return to the window to complete information or proceed without completing information.
- When required fields are left incomplete, the Audit Trail logs an entry.

Note: Some fields are filled in automatically or will not trigger a popup.
- StudentStatus: Only triggers a popup for a new patient. If the required field is ignored, a non-student status is automatically assigned.
- PrimaryProvider: Automatically assigned and will not trigger a popup, unless Primary Provider defaults to Select Provider in patient edit and add family is checked in Family Module Preferences (637).
- BillingType: Will not trigger a popup.

Mark Fields as Required
Field Type: Select which area to apply required fields to.
- PatientInfo: Mark fields as required on the Edit Patient Information (62) or Add Family Window (1652).
InsPayEdit: Mark fields as required on the Edit Insurance Payment window. See Finalize Insurance Payment (231)

Available fields: Lists all fields that can be marked required. Field options vary depending on which options are enabled in Show Features (806).

Required fields: Lists all fields currently marked required. Click on a field to view a description of the requirement under the grid.

Conditions: (optional) Add specific conditions that require a field to be completed. An X will show in the Conditions column.

Highlight an available field, then click the right arrow to add it to the Required Fields list. To select multiple fields at once, press Shift + click. To remove a required field, select it and click the left arrow.

Optional: Set specific conditions that require a field to be completed.
- Highlight the required field.
- Click Add under Conditions.

Validation of Medicaid ID and State
If Medicaid is turned on in Show Features, the MedicaidID and MedicaidState fields list as Available Fields. In addition to designating the fields as required, you can also turn on validation that ensures the number of digits in the Medicaid ID is correct for the entered state.

1. Add MedicaidID and/or MedicaidState to the Required Fields list.
2. Highlight MedicaidID or MedicaidState.

- Select the Condition type, operator, and value. Options will change based on the criteria selected.
- Set multiple conditions for a required field. In this case, the field is required only when all of the conditions are met.
- Click OK to save.

Click OK to save required field settings.
3. Check Validate the number of digits in MedicaidID to be correct for that state turn on validation. This box is checked by default when MedicaidID or MedicaidState is added as a required field. When checked, a Medicaid ID Length column will also show in the state abbreviation list. See State Abbreviations (1270) to enter the number of digits in a Medicaid ID by state.

How Medicaid ID validation works: When user clicks OK on the Edit Patient Information window, Open Dental will check if the number of digits entered for Medicaid ID matches the Medicaid ID Length entered for the state in the State Abbreviations list. If not, the user will be warned that required fields are missing or incorrect. If they return to the window (click Cancel), a red exclamation point will show next to the State field. Hovering over the field will show a message that indicates the required ID length.

Family Relationships
In Edit Patient Information (62), near the center, is a list for Family Relationships.
This is not a commonly used option, however a relationship may determine who is considered an Authorized Representatives (1579) in the patient portal.

**Add**: Add a family relationship.

**Defaults**: When clicked, the following occurs:
- Deletes all current relationships.
- Takes oldest female in the family and makes her the mother for all family members with position of Child.
- Takes oldest male in the family and makes him the father for all family members with a position of Child.
- The relationships will automatically be applied to all family members.

### Manually Add a Relationship
Manually entered relationships do not automatically copy to other family members.

Click Add.

Patient: The patient record currently selected.

**Family Member**: Click [...] to pick a family member. You can select from immediate family members, or click Other to select another patient.

**Guardian**: Check this box designate the family member as the patient’s guardian. The family member will have access to the patient's health information in the Patient Portal Feature. The relationship will also show in the appointment and in the Family Module, Patient Information area (first name, relationship abbreviation). For appointments, guardians must be set to show in the appointment view. For Patient Information, add the Guardians field to the list of fields showing in Display Fields (900), Patient Information.

**Relationship**: Click the dropdown to select the family member's relationship to the patient.
- Brother (br)
- Caregiver (cg)
- Child (c)
- Father (d)
- Foster Child (fc)
- Friend (f)
- Grandchild (gc)
- Grandfather (gf)
- Grandmother (gm)
- Grandparent (gp)
- Guardian (g)
• Life Partner (lp)
• Mother (m)
• Other (o)
• Parent (p)
• Self (se)
• Sibling (sb)
• Sister (ss)
• Sitter (s)
• Spouse (sp)
• Stepchild (sc)
• Stepfather (sf)
• Stepmother (sm)

Click OK to save.

**About Family Relationships**
The family relationships feature was enhanced in version 14.1 due to EHR certification requirements for immunizations and in response to a feature request for more relationship options. Family relationships are mostly for information only. However if a person is set as a Guardian, this also gives the guardian access to the patient's health information in the Patient Portal.

Defaults: This button was originally used for insurance reasons, but has been enhanced for EHR.

**Edit Patient Information: EHR Misc Tab**
The EHR Misc tab is used for immunization data.

In the **Edit Patient Information** window, click the EHR Misc tab.

![EHR Misc Tab](image)

This tab is only visible when EHR is turned on in **Show Features**.

- **Mother's Maiden First Name**: The patient's mother's first name.
- **Mother's Maiden Last Name**: The patient's mother's maiden last name.
- **Date Time Deceased**: Entering a date will lock the patient's age as of the deceased date. This information is also used for Syndromic Surveillance data.

**Referrals**
Use referrals to track income from different sources, create referral slips or letters, and track treatment referred to other providers.

In the **Family Module**, double-click Referrals.
There are three types of referrals; referred from, referred to, and refer custom. By default, when a referral type is added to a patient, it is listed in the referral section of the Family module, Patient Information area. To hide the section, remove Referrals from the fields showing in the Patient Information, Display Fields (900). The Referrals label can also be customized in Display Fields. The label acts as the section title until a referral is added, then is used as the custom referral label. Customize the referral section color in Definitions: Misc Colors (876).

Add / Edit Referrals

Double-click the referrals section to add or edit a referral source. The Referrals for Patient window will open with the patient's existing referral sources.

Add a referral by clicking one of the referral types, then single-click a referral from the Referrals (1268) list to select a referral source.

Note: If the referral is a patient, some fields can only be edited from the Edit Patient Information (62) window.

Referred From: Select when a patient is referred from a source (e.g. internet, mailing, etc) or when referred from another provider or patient.

Refer To: Select when a patient is referred to another provider. To track procedures, create this type of referral from the Procedure Info (303) window (see Track Referrals below). When referring to a provider the EHR Summaries of Care (445) is automatically sent to the Patient Portal and a WebMail (1672) notification is sent to the patient. To turn off automatic summary of care WebMails, see EHR Settings (711).

Refer Custom: Select to use the custom referral label. Custom referrals are useful for entering referrals you do not want to report on. Custom referrals are not tracked on referral reports but are an additional option in the Letters dropdown.

Added referrals will list in the Referrals Attached grid. To send a Referral Slip (79), select the referral then click Referral Slip or to send a Referral Letter (1681), click Letter from the Main Toolbar (1649). Double-click an attached referral to open the Edit Referral Attachment window to edit or enter more details.
Referral Type: Defaults to the type selected when the referral was created. Select a new type to change.
Name: First and last name or description of the referral source. Click Edit Referral to edit the referrals general information (affects all patients with this referral) or click Change Referral to select another referral source for this patient.
Notes about referral source: Auto-populates with the notes from the referral.
Referring Provider: If referring to another provider, this auto-populates with the patient's primary provider after clicking Refer To. To change, click [...] and select another provider. To clear the selection, click None.
Date: The date the referral source was attached to the patient.
Order: The order the referral source is listed. To change, in the Referrals for Patient window, select the referral then use the Up/Down arrows.
Status (if referred out): The status of the treatment that has been referred to another provider. Use the dropdown to select a different status.
Patient note: Referral notes specific to this patient. Also shows in the Referrals Attached grid under Notes.
Referral Slips: A list of referral slips generated for this source. Double-click a slip to open. To generate a slip, see Referral Slip.(79).
Transition of Care: Check if this is a referral for EHR Summaries of Care(445).
Procedure: Abbreviation of a procedure that has been referred to another provider (see Track Referrals below for how to attach).
Date Proc Completed: Enter the date the referred out procedure was completed.

To save changes click OK. To remove the referral from the patient click Detach.

Track Referrals
When a patient is referred to another provider for treatment, the treatment can be tracked. First, set the procedure status to Referred Out. Either double-click a procedure and select Referred Out from the Procedure Status dropdown in the Procedure Info(303) window or in the Chart Module(298), check the Entry Status Referred, and Enter Treatment(301).
Next, in the Procedure Info window, click [...] next to the Referral field to select the provider the procedure is being referred to. The Referrals window will open with a list of providers the patient has been referred to.

Click Refer To, then single-click a provider from the Referral List(1268) and click OK to select the referred provider. Click Referral Slip to generate the referrals default Referral Slip(79) then close the Referrals window to finish attaching the provider to the procedure.

The referred out procedure text and graphic color set in Definitions: Prog Note Colors(884) and Definitions: Chart Graphic Colors(855) is used. The referral information is also added to the Family module, referrals section. To update the status of the referred out procedure, double-click the referral and Edit Referral Attachment (see Add/Edit Referrals above).

The procedure fee for a referred procedure will only be $0 if the procedure is originally charted with a Referred Out status. If the procedure is charted, then the status changes to Referred Out, the procedure fee must be changed to $0 manually.

As referrals are added to patients, various reports may be run to see referral counts, track production, and referred out procedures. Referred Procedure Tracking Report(1367): Track treatment referred to another provider. Referral Analysis Report(1365): Track production for referrals in a date range. Query Examples: Choose from a variety of user requested reports. Use the Return Queries About dropdown and select Referral to narrow the list. Referral - Raw Report(1363): Create a custom referral report. Referral List(1268): Double-click a referral source from the list to quickly view a list and count of patients where the referral is used.

Referral Slip
Create referral slips when referring patients to other providers.

In the Referrals(76) grid, double-click. With a referral source selected, click Referral Slip.
Add notes or edit the referral slip information from the Fill Sheet window. The pale yellow areas indicate fields that may require additional provider input such as notes. Use the mouse to *pen* information onto the sheet, if needed.

**Date Time:** The date and time the referral slip was created.

**Description:** The default sheet description.

**Internal Note:** Text entered here is only visible in the Fill Sheet window

**Eraser Tool:** Check to change the mouse function from *pen* to eraser and erase the pen edits.

**Change Patient:** If the referral slip was created for the wrong patient, click to select the correct patient.

To send the referral slip to the [Kiosk Manager](1444) for patient input click **To Kiosk**. If the patient is filling out multiple forms in a specific order, enter the order number in **Show Order in Kiosk** field. For example, enter the number 3 to make it the third form in the kiosk.
When the slip is complete, click **Print** or **Email** to send. To print and email a copy of the slip, click **Print/Email**. Enter the number of copies to print and check whether to email the slip to the patient, to the referral source, or both. If both, the **Edit Email Message**(1656) window will appear for each recipient.

The slip is saved in the **Account Module**(150), **Communication Log**(1654), **Chart Module**(298), Progress Notes, and in the **Edit Referral Attachment**(76) window of the referral source. To also save a PDF copy, click **Create PDF**.

To customize and create new referral slips, see **Referral Slip Layout**(1180). Assign custom slips to a referral source in the **Referral List**(1268).

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**Insurance Plan**

In the **Family Module**(59), double-click an existing insurance plan.

![Insurance Plan Window](image)

Alternatively:
- Double-click a plan in the **Insurance Plans**(1244) list.
- **Add Insurance**(112) to a patient.

Note: Set default options for this window in **Family Module Preferences**(637).

---

**Patient Information**
This information is specific to the patient.

- In the database, it is stored in a table called `patplan`.
- Set the background color in Definitions: Misc Colors(876), Family Module Coverage.
- If you are editing a plan which is not attached to any patient as current coverage, this upper section may be blank.

**Relationship to subscriber:** (required) If the patient is the subscriber, the default is Self. Otherwise there is no default.

**Optional Patient ID:** No longer used by most insurance companies in the U.S.

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**Note:** In 2012, most carriers switched to each patient being their own subscriber with a subscriber ID. If you plan to send e-claims in 5010 format, you may need to drop patients from their family's plan and recreate them with subscriber as self, using the patient ID instead of the subscriber ID.

**Drop:** Remove a plan when a patient changes carriers or no longer has insurance coverage. Dropping an insurance plan does not delete the plan; it will still appear in the Insurance Plans for Family window. See Drop Insurance Plan(126).

**Patient Plan ID:** A system generated unique identifier that is useful for third party reporting.

**Order:** Determines the order this plan will show in the Family module (primary, secondary, or supplemental insurance). 1 = primary, 2 = secondary, etc. The number can be changed at any time.

**Eligibility Last Verified:** The date that patient insurance eligibility was marked verified (manually or using the Insurance Verification List(49)). Click Now to insert today’s date.

**Pending:** Informational only. Identifies insurance information that is incomplete or unverified. If you don’t even know the insurance company name, create a dummy carrier called Pending, check the Pending box, then come back later and fix it.

**Hist:** View history for procedures completed outside of the office. This is useful when tracking insurance frequencies. See Insurance History(136).

**Ortho:** View patient-specific information about the next time an orthodontic claim will be automatically generated when using Ortho Auto Claims(1425).

- **Fee:** Defaults to the fee set on the Ortho Tab. To override it for the next claim only, uncheck Use Default Fee, then enter the new fee.
- **Next Claim Date:** The date the next claim will be created using the Auto Ortho Tool. Defaults to a date based on the last auto-created claim and the frequency (Auto Proc Period).

**Adjustments to Insurance Benefits:** Enter any benefit amounts that have already been used this year (e.g. if the patient had treatment done at another office, or if you have just had a data conversion). Click Add to adjust benefits for amounts used so far. The amount automatically clears when a new benefit year begins. See Adjustments to Insurance Benefits(106).

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### Changing a Plan vs Creating a New Plan

Two radio buttons in the lower right determine whether plan editing insurance plan information updates an existing plan for all subscribers or creates a new plan.

- **Create new Plan if needed**
- **Change Plan for all subscribers**

**Create New Plan if needed:** Only select if you need to create a brand new plan. A value must change in one of the Fields that Trigger New Plan(107). If no changes are made, a new plan will not be created.

**Change Plan for all subscribers:** We recommend setting this as the default to prevent spawning of duplicate insurance plans. See Family Module Preferences, InsPlan option at bottom, Change Plan for all subscribers is default. This option should normally be checked.

Changing benefit information will not trigger a new plan (with the exception of benefit year). Changed benefits are at the plan level and apply to all subscribers.

If an existing plan is selected, the radio button setting is Create New Plan, and you make changes to an insurance plan information fields, close the Edit Insurance Plan window before adding or editing benefit information for the new plan. If
you do not and simply edit benefit amounts, any benefit changes will apply to both the new plan and all subscribers of the original plan.
1. Click OK.
2. Reopen the new plan.
3. Double click to edit Benefit Information.

To make changes to an existing plan, see Change Insurance Plan Information(124) for steps on how to change employers, carriers, or update plan information for all subscribers vs single subscriber, etc. This may help avoid duplication errors.

**Plan Info Tab (Insurance Plan Information)**

This information is specific to the insurance plan and can only be edited by users with the Insurance Plan Edit security permission.

**Audit Trail**: View changes made to the insurance carrier, insurance plan, benefits, or employer. This audit trail is accessible to all users.

**Pick From List**: Select an existing insurance plan from the Insurance Plans(1244) list. Requires the Change existing Ins Plan using Pick List security permission. Alternately, drop the insurance plan before picking a new plan.

**Insurance Plan ID**: A system generated unique identifier that is useful for third party reporting and to filter the Insurance Plan List.

**Medical Insurance**: Check this box if this is Medical Insurance(128) rather than dental. Only visible if Medical Insurance is turned on.

**Employer**: Optional. Will also be added to the Employers(1235).

**Carrier**: Required. Click [...] to pick an existing carrier from the Carriers(1237) list or enter carrier information manually. If you manually enter carrier information that doesn't exactly match an existing carrier, or if you change carrier information, a new entry is automatically added in the insurance carrier list.

Note: If you have the Insurance Plan Edit permission and change information in any carrier field, a new carrier is created. Also, if another user has a plan open with the same carrier, and carrier information is edited by a user with the Insurance Plan Edit permission, a new carrier is created.

**Electronic ID/Payor ID**: Provided by the insurance company if they accept E-Claims(645). Enter the ID manually or click Search ID to search the Payor ID list. If the carrier does not accept electronic claims, you have two choices.

- Leave the ID blank and submit the claims electronically anyway. If the clearinghouse cannot match the insurance carrier name with a known name, the claim will be printed by the clearinghouse and mailed.
- Select a don't send electronically option for Send Electronically (see below). These claims will be marked as paper.

**Send Electronically**: Determines whether e-claims can be sent electronically for this insurance plan. Defaults to the setting for the carrier (see Carriers(1237)) but can be changed by insurance plan.

- Send Claims Electronically: Allow sending e-claims for this plan.
- Don't Send Claims Electronically: Do not allow sending e-claims for this plan (e.g. if you must print and mail).
- Don't Send Secondary Claims Electronically: Do not allow sending secondary e-claims (e.g. when plan requires that secondary claims are mailed with a copy of the primary EOB).

**Group Name**: Typically the same as the employer. Used to identify differences in plans (i.e. if the same employer has multiple plan options.)

**BIN**: Benefit Identification Number. Issued by the carrier.

**Group Number**: Issued by the carrier.

**Other Subscribers**: Indicates the number of subscribers who use or have used this plan. Click the down arrow to see other subscriber names.

**Plan Type**: The type of plan. See Insurance Plan Types(114) for more information.

- **Category Percentage**: Traditional percentage insurance plans.
• **PPO Percentage**: Preferred Provider Organizations. To set this as the default for new plans, see Family Module Preferences.
• **PPO Fixed Benefit**: In-network plan that calculates write-offs and covers insurance at a fixed amount.
• **Medicaid or Flat Co-pay**: All categories will be computed at 100% coverage. Disables all other percentages.
• **Capitation**: HMO and DMO type plans. Disables all other percentages.

**Fee Schedule**: The fee schedule used by this plan. If *none*, the provider's fee schedule is typically used. The only exception is if a fee schedule has been set on the Edit Patient Information(62) window (e.g. a discount/cash fee schedule); this overrides other fee schedules.

**Other Fee Schedules**: See Types of Insurance Plans for more information.
• **Patient Co-pay Amounts**: Used for patient co-pays per procedure.
• **Carrier Allowed Amounts**: Used for out-of-network fee schedules.

**Other Ins Info Tab**

**Use Alternate Code**: Use alternate procedure codes when submitting claims (e.g. Medicaid). To associate alternate codes (Alt Code) with procedure codes, see Edit Procedure Code(1200).

**Substitution code options**: These options determine whether or not estimated fees for procedures are downgraded based on substitution codes. Associate substitution codes to procedures in the Procedure Code List. Also see Estimate Downgrades(137).

• **Don't Substitute Codes** (e.g. posterior composites):
  o Checked: Do not use substitution codes to calculate downgraded insurance estimates. All estimates will be based on the fee of the completed procedure and substitution codes will be ignored.
  o Unchecked: Use the substitution code associated with the procedure (if entered) to calculate downgraded insurance estimates. This will affect all procedures with substitution codes, unless you specify which substitution codes to include/exclude.

• **PPO substitution calculate writeoffs**: Select whether insurance estimates calculate write-offs when a procedure is substituted. Only applies to PPO plans.
  o Checked: Calculate write-offs when a procedure code is substituted. The write-off is calculated between the office fee and the fee for the originally charted procedure.
  o Unchecked: Do not calculate write-offs when a procedure is substituted.

• **Subst Codes**: Control which procedure codes have downgraded estimates for this insurance plan (also uncheck Don’t Substitute Codes).

**Claims show UCR fee, not billed fee**: Show the UCR fees of the treating provider on claims instead of the insurance fee. To set the default value for new plans, see Family Module Preferences.
Hidden: Hide this insurance plan in the Insurance Plan List so it can't be copied for use by other subscribers. If this plan has multiple subscribers, and you want to hide it for all subscribers, you must also select the Change Plan for all subscribers radio button.

Claims show base units: Check this box to show base units on claims. Usually applies to medical insurance claims only. Base units are entered on the Edit Procedure Code window.

Claim Form: The form used for printed claims. Set the default in Claim Forms(641).

COB Rule: Select a Coordination of Benefits (COB) (134) rule option. Set the default option for new plans in Family Module Preferences.

Filing Code: For e-claims. If the carrier has an insurance filing code, select it. By default Commercial Insurance is used. If the filing code is incorrect, then the carrier will reject the claim. See Insurance Filing Codes(686).

Filing Code Subtype: If the insurance filing code has a specific subtype, select it.

Billing Type: The plan's billing type. If the preference in Family Module Preferences for New patient primary insurance plan sets patient billing type is checked, and this is a new primary insurance plan, setting a billing type here will also assign the billing type to the patient on the Edit Patient Information window. (If you change an existing plan's billing type, it will not automatically change the patient's billing type).

Exclusion Fee Rule: Only for PPO plan types. Select an option for how procedures not covered by insurance are billed. Exclusions are defined using Other Benefits(94), or by setting coverage at 0%.
- Practice Default: Uses Exclusion rules defined in Family Module Preferences(637).
- Do Nothing: Exclusions will be billed normally based on plan fee schedule.
- Use UCR Fee: Exclusions will be billed at the full UCR fee rather than the negotiated rate.

Ortho Tab
The Ortho tab shows when Show ortho case in account module is selected in Ortho Setup(927). Use it to enter plan information for orthodontic claims. This information will also show in the Ortho Case tab. Information can only be changed by users with the Insurance Plan Ortho Edit security permission.

Ortho Claim Type: Select how the carrier wants to receive orthodontic claims.
- Initial Claim Only: Send a single orthodontic claim for the initial procedure.
- Initial Plus Visit: Send an orthodontic claim for the initial procedure and each subsequent visit.
- Initial Plus Periodic: Send an orthodontic claim for the initial procedure, then send claims periodically for a certain fee and procedure. Selecting this option makes claims for this carrier eligible for automatic claim generation using the Auto Ortho Tool.

If Initial Plus Periodic is the claim type, the following fields are also editable.
- Ortho Auto Proc: The procedure code to put on auto-generated orthodontic claims. Set the default in Ortho Setup. Click [...] to select a different procedure. Click Default to reset the default. Only the first 5 digits of procedure codes are sent to insurance.
- Ortho Auto Fee: The procedure fee billed in the claim.
- Auto Proc Period: How often the claim will be auto-generated (Auto Proc Period).
- Wait 30 days before creating the first automatic claim: If the insurance carrier requires that you wait a minimum amount of days after the initial visit before sending periodic claims, check this box. When checked, the next claim will show in the Auto Ortho Claim list 30 days after the initial procedure is completed.

Miscellaneous
Plan Note: Enter notes specific to the insurance plan. This note will show for all subscribers on the plan. These appear in bold red in the insurance grid.

Label: Print the insurance carrier name and address on an individual mailing label.

Delete: If the plan has only one subscriber, this will delete the plan (remove it from the Insurance Plan List). If there are other subscribers, the plan will only be removed from this subscriber and associated family members on the plan.

Subscriber Information
The subscriber is set when first creating the insurance plan. To change the subscriber, click Change.

**Subscriber ID**: Required and cannot be blank. The SSN entered on the Edit Patient Information: Other Tab (67) is automatically used as the ID, but it can be manually changed. If the patient has Medicaid, use the Medicaid ID number, then also fill in the Medicaid ID on the Edit Patient Information window.

**Effective Dates**: Only used when adding a waiting period to benefits, otherwise this is mostly informational. The end date does not terminate the plan; you must drop a plan to not use it. Set benefit renewal dates (calendar year or service year) in the Benefit Information section.

**Release of Information**: Check this box if the patient has signed a form that states that the patient consents to the use and disclosure of protected health information to the insurance company in order to carry out payment activities. Signature on File will show in box 36 of the claim form.

**Assignment of Benefits**: Determines whether insurance payments are paid directly to the patient or provider.
- **Checked**: Insurance payments are sent directly to provider.
- **Unchecked**: Insurance pays patient. Typically used in offices where patient pays upfront. See Claims with No Payment on the Receive Claim (229) page for claim information.

  - **Note**: If this box is disabled, the user does not have permission to change this setting (see Permissions (1118), Insurance Plan Change Assignment of Benefits.).
  - **Changes made to Assignment of Benefits are logged in the audit trail.**

**Notes**: Notes specific to the subscriber and associated family members. These appear in bold red in the insurance grid.

**Benefit Information**
Double-click the grid to enter Benefit Information (86).

Benefit information can only be edited by users with the Insurance Plan Edit security permission.

**Request Electronic Benefits**: If you have set up Electronic Eligibility and Benefits (108) with a clearinghouse and a Subscriber ID is entered, click Request to request benefit information or History to view a history of requests.

**Import Benefits**:
- If you have set up the Trojan Bridge (1072), click Trojan to copy exported Trojan data. The Trojan ID number shows at the right.
- If you have set up Insurance Answers Plus (1012), IAP shows.
- Click Note to view benefit notes if available. They are created when importing benefits and usually read only.

**Benefits Last Verified**: Indicates the date that insurance benefits were last marked verified (manually or using the Insurance Verification List (49)). Click Now to insert today's date.

**Don't Verify**: Check this box to always exclude this plan from the Insurance Plan Verification List. To also exclude patients with this plan, see Insurance Verification Setup (627).

**Benefits**
In an Insurance Plan (81), at the lower right, is the Benefit Information.
These percentages and amounts are used to calculate procedure estimates and insurance remaining estimates. Benefits apply to all subscribers on the plan. If different subscribers have different benefits, create different plans. If you change benefits for a plan, all Claim Procedures (claimprocs)(221) estimates will also change, including those on current and sent claims.

To change or view benefits, double-click anywhere in the grid. To change benefit information, the Insurance Plan Edit security permission is required.

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</tr>
</tbody>
</table>
There are two view options for the Edit Benefit window.

- **Simplified View** (default): This view allows quick data entry and organizes benefit information by field. See below for a description of each field.
- **Row view**: If Simplified View is unchecked, benefits are represented by rows. See Edit Benefits - Row View(91). This is useful if you don't use typical insurance categories (e.g. are in a country other than the U.S. or Canada).

Note: Every benefit is stored as a row in the database. This format matches how electronic benefits from insurance companies are received. The dental industry is gradually moving towards electronic benefit requests, which will save you time and provide accurate benefit information without any phone calls.

**Simplified View**
The fields that show in Simplified View are described below. Click in a field to enter values. Leaving a box blank is different than entering a zero; blank means unknown.
Note: Insurance Categories (683) must have at least one of each e-benefit category present (Accident, Crowns, Diagnostic, Endodontics, General, Maxillofacial Prosth, Oral Surgery, Orthodontics, Periodontics, Prosthodontics, Restorative, Routine Preventive, and Diagnostic XRay).

Benefit Year: The renewal date used to calculate benefits and the current benefit year. It applies to all benefits in the window.
- If plan follows calendar year (starts in January; ends in December): Check this box.
- If the plan follows a service year (starts in a month other than January): Uncheck the box, then enter the two-digit month when benefits renew in the Month field (e.g. October = 10, February = 02).

Annual Max: The maximum annual amount per individual or family. If left blank, Insurance Remaining Calculations (295) cannot be done.

General Deductible: The amount the individual or family pays out of pocket before the insurance company will begin to pay. Applies to procedures in the None or General category and resets at the start of the new service or calendar year.
- Individual: Enter the deductible amount for the individual. If the Family deductible has already been met, the individual deductible will not be applied.
- Family: Enter the deductible amount for the entire family. If the Family deductible has been met by a family member or combination of family members, individual deductibles are no longer applied.

Note: The deductible is applied before the insurance estimate is calculated. For example, if you have a $125 filling covered at 80% and the individual deductible is $50, the insurance estimate is $60 ($125 - $50 deductible x 80%) and the patient portion is $65 ($50 deductible + $15 amount left over after insurance).

Categories:
- Percentages: The percent covered per procedure for each category. For quick entry of the same percentage amount, enter the amount under Quick% and it will automatically populate the associated fields to its left.
- Deductibles (if different): The deductible per individual or family for a specific category, if it is different than the General Deductible. Zero indicates there is no deductible at all. If blank, the General Deductible is used. See Deductibles (103).
- Waiting Periods (if applicable): The number of months a patient must wait before insurance will cover a procedure. An effective date must be entered in the Insurance Plan for waiting periods to calculate.

Fluoride through Age: Creates an age limitation for fluoride procedures. Bases estimates off codes selected in the Treatment Plan Module Preferences (703).

Sealants Through Age: Creates an age limitation for sealant procedures. Bases estimates off codes selected in the Treatment Plan Module Preferences.

Frequencies: Plan frequency limitations for categories. Enter a value, then click the dropdown to select the frequency. For example:
- Every # Years: Every 2 years,
  - i.e. one procedure covered every 2 years. Uses the patient's calendar or service year.
- # Per Year: 2 per year,
  - i.e. two procedures every year.
- Every # Months: Every 2 months,
  - i.e. one procedure every 2 months.
- # per 12 Months: 2 per 12 months,
  - i.e. two procedures in the last 12 months. Uses the last 12 months from today.

More: Click to add additional Benefit Frequencies. The associated procedure codes for each category are set in the Treatment Plan Module Preferences.
For each procedure code with a frequency limitation, a row will show in the Family module, Insurance Plan area for easy reference.

**Ortho**: Enter orthodontic benefit information.
- **Lifetime Max**: The maximum orthodontic benefit. This is separate from the individual and family Annual Max above as long as the insurance category spans are set correctly. The correct setup (and default) is to have an Ortho span of D8000 to D8999 and to exclude that span from the General category.
- **Percentage**: The percentage per procedure that is covered. This will affect insurance estimates.
- **Ortho Through Age**: Used with codes that fall into Ortho insurance category span. This will affect insurance estimates.

**Other Benefits**: Benefits that are specific to this insurance plan. Useful for incentive plans, or to override typical insurance percentages or amounts. Only specific scenarios are known to work and adding other benefits is rare. See Other Benefits(94).

**Notes**: This is the same as the subscriber note on the Edit Insurance Plan window. Certain types of benefits are not easily codified, so do not have a box. These types of benefits are just entered as subscriber notes for now. Examples of benefits which get entered as notes are:
- **Missing tooth exclusion** (a clause that states that if a tooth was extracted before the patient became insured through them, that they will not cover any replacement teeth including a partial or a bridge).
- **Wait on major treatment** (usually 6 months to a year).
Benefit Calculation Logic
Advanced users might be interested in the Benefit Logic (93).

Edit Benefits - Row View
In the Edit Benefits (86) window, uncheck the Simplified View box.

- Simplified View: Check/uncheck the box to switch between Simplified View (86) and Row View.

This is useful when you don't use typical Insurance Categories (683) (e.g., in a country other than the U.S. or Canada).
• **Benefit Year:** The renewal date used to calculate benefits and the current benefit year. It applies to all benefits in the window.
  o If plan follows calendar year (starts in January; ends in December), check this box.
  o If the plan follows a service year (starts in a month other than January), uncheck the box, then enter the two-digit month when benefits renew in the Month field (e.g. October = 10, February = 02).

• **Benefits:** Each row represents a benefit. Double click to edit.

• **Notes:** The same as subscriber notes on the Insurance Plan(81). Certain types of benefits are not easily codified, so they do not have a box. These types of benefits are just entered as subscriber notes for now. Examples of benefits which get entered as notes are:
  o Missing tooth exclusion (a clause that states that if a tooth was extracted before the patient became insured through them, that they will not cover any replacement teeth including a partial or a bridge).
  o Wait on major treatment (usually 6 months to a year).

**Add or Edit a Benefit**
To see examples of other benefit scenarios that are known to work, see Other Benefits(94).

Click Add, or double click a row to edit.

![Edit Benefit](image)

• **Patient Override:** Check this box if this is an incentive plan benefit where each family member is at a different percentage. These benefit changes will only affect this patient and this plan.

• **Category or Proc Code:** Category refers to the insurance category the benefit applies to. To apply to a specific procedure code instead, select None as the category and enter the code.

• **Type:** Some types affect Insurance Remaining Calculations(295); others are informational only.
  o ActiveCoverage: informational only
  o CoInsurance: affects calculations for percentages, not amounts.
  o Deductible: affects calculations
  o CoPayment: informational only
  o Exclusions: affects calculations based on exclusion settings from Family Module Preferences(637).
  o Limitations: affects calculations for amounts, but not percentages.
  o Waiting Period: affects calculations. Insurance plan must have an effective date entered for calculations to work.
- **Percent**: The percentage of coverage for this category or procedure code.
- **Amount**: The dollar amount that is covered for this category or procedure code.
- **Time Period**: Some options affect insurance remaining calculations; others are informational only.
  - Service Year: affects calculations
  - Calendar Year: affects calculations
  - Lifetime: information only
  - Years: information only
- **Quantity/Qualifier**: If there is a frequency limitation or waiting period on a category or procedure, enter a number and select the qualifier that matches.
  - None:
  - Number of Services:
  - Age Limit:
  - Visits:
  - Years:
  - Months:
- **Coverage Level**:
  - Individual: Apply this benefit change to all individual subscribers on this plan. Most commonly used for maximums or deductibles.
  - Family: Use when a family has a benefit that is in addition to the individual coverage of the subscriber (e.g. individual preventative benefit is $250 per year, but the family has a total cap of $500). This is used when specific categories of coverage have specific limits.
  - None: For use with benefits that do not specify a limit (e.g. a percentage, co-pay).

## Benefit Logic
This page describes the logic used to calculate Insurance Benefit Information(86).

### Kinds of Benefits
There are six different kinds:

- **Limitation Amount**: Maximums, Ortho Lifetime maximums, family, individual, fluoride.
- **CoInsurance %**: For all, for Category, or for one procedure. A matching patplan % always wins over a plan %.
- **Deductible**: General, or for Category. Even for procedure. Family or individual.
- **Exclusions**: Example: cosmetics not covered. $0 coverage.
- **CoPayment**: This is handled in fee schedules instead of in Benefits. Do not use.
- **Limitation for time period**: Exams per year, etc. These are only included in calculations if Frequency Limitations(104) is enabled.

### Benefit Types used by Open Dental
- **ActiveCoverage**: Not usually used. Would only be used if you are just indicating that the patient is covered, but without any specifics.
- **Percentage**: aka CoInsurance.
- **Deductible**: Dollar amount.
- **CoPayment**: Informational only.
- **Exclusions**: Services that are simply not covered at all.
- **Limitations**: Covers a variety of limitations, including max, frequency, fee reductions, etc.
- **Waiting Period**: Services that require a waiting period before insurance will cover the benefit. An effective date is required in Insurance setup for calculations to work.
Timing of Calculations
Insurance estimate calculations are very complex, so they are only calculated at specific times. These estimates are calculated at the following specific times:

- Viewing the Treatment Plan module (all procedures for the patient).
- Adding a new procedure.
- Editing a procedure.
- Creating a claim (the procedures on the claim).
- Deleting a claim.
- Closing the edit procedure window.

Hierarchy
Benefits are calculated on a single procedure at a time. This procedure has a specific procedure code, and only benefits which apply to that code are considered. There can be multiple benefits all applying to a single code. As long as they are of different kinds, there is no ambiguity. If they are of the same kind, then a hierarchy needs to be considered. From broadest to most specific:

- No Category.
- Category, top to bottom.
- Single procedure.
- Lower, more specific items in the list always take priority over broader ones higher up if they are of the same kind.

Awareness of other Procedures
Even though benefits are calculated on one procedure at a time, there frequently comes a moment in the calculation when it is necessary to know about benefits applied to other procedures. The time span can be large, and information may be needed about multiple patients. For example, an ortho lifetime max needs to know about all procedures, regardless of how long ago they were performed. And a family maximum can require knowledge of procedures from all other family members.

When considering other procedures, completed procedures that have been attached to claims are always considered, whether the actual payment or just the estimated payment. For TP procedures, only those that come before the current procedure are considered. The order is as displayed in the TP module.

Frequency Limitations(104): Only procedures on claims that have been sent AND received are considered when calculating estimates.

The internal mechanism for obtaining information about other procedures is as follows. Before starting the calculation, a single query is used to grab a list of objects. Each object contains a date, proccode, ins paid/est, and deductible paid/est. The list contains information from all completed procedures attached to claims as well as adjustments to insurance benefits contained within InsPlans. To keep the list shorter, a date range is calculated first based on the information in the list of benefits. Also, other family members are only included if there are family level benefits. Family members are defined as other patients with the same insurance plan, whether actually in the family or not.

Other Benefits
In the Edit Benefits(86) window, at the bottom, is the Other Benefits grid.
Other Benefits are additional benefits or overrides added to insurance plans. For a detailed explanation of options on the Edit Benefit window, see \textit{Edit Benefits - Row View}\textsuperscript{(91)}. Other Benefits are useful when setting up an incentive plan, or when overriding typical insurance percentages or amounts. Only specific scenarios listed below are known to work. Combinations not listed will display in the benefits section for informational purposes only.

Click Add, or double-click an existing benefit to edit.

1. **Override a procedure or category benefit percentage for a specific patient but not everyone on the plan (e.g. incentive plans)**

This may be necessary when you have an incentive plan and each family member is at a different percentage.

2. **Cover a procedure at a different percentage**

For example, nitrous oxide is covered at 50\%, even though other procedures in that Insurance Category are not covered (0\%).
3. Some work does not apply toward regular annual max
This may be necessary when you need to add a benefit that does not apply to the annual max. For each category you want to exclude from the annual max, create a new benefit.

Examples:
• CHIP
• Some Medicaid plans
• A plan that has a x-ray limit of $150 for the year, with everything else covered at a flat co-pay amount.
• Diagnostic, preventive, and x-rays that do not apply to the annual max.
• A specific procedure code is covered up to a set amount. Enter the procedure code with the amount it will be covered up to by insurance.
4. Each family member has a different annual maximum
For each family member, add an Other Benefit using the settings below.

Note: Remove the Annual Maximum values entered in the Edit Benefits window first. Otherwise, these annual maximum Other Benefits will not be applied.
5. No max for a category (e.g. preventive).

<table>
<thead>
<tr>
<th>Pat</th>
<th>Level</th>
<th>Type</th>
<th>Category</th>
<th>%</th>
<th>Amt</th>
<th>Time Period</th>
<th>Quantity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>Limitations</td>
<td>Preventive</td>
<td></td>
<td>100,000</td>
<td></td>
<td>CalendarYear</td>
<td></td>
</tr>
</tbody>
</table>
You can also set the time period as service year if appropriate. Test in the treatment plan module (e.g. add a $10000 preventive procedure and a $200 filling to make sure it behaves as expected.)

6. Set an age limitation
The age limit is through the designated age. For example, entering 16 will cover the patient until their 17th birthday. Note: Fluoride, Sealants, and Ortho age limitations can be set from the Edit Benefits window.
7. There is a waiting period on a specific code
Waiting periods can be set by category from the Edit Benefits window. Individual codes can be done using the setup below. An effective date is required to be entered in the Insurance plan for the calculations to work.

<table>
<thead>
<tr>
<th>Pat</th>
<th>Level</th>
<th>Type</th>
<th>Category</th>
<th>%</th>
<th>Amt</th>
<th>Time Period</th>
<th>Quantity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>WaitingPeriod</td>
<td>D2740-AllCerCm</td>
<td></td>
<td></td>
<td>CalendarYear</td>
<td>1 Years</td>
</tr>
</tbody>
</table>
8. Certain Codes or Categories have Exclusions

Some states or municipalities allow uncovered procedures to be charged at the full UCR fee with no writeoffs. Create an Other Benefit to define which procedures or categories are subject to this Exclusion.

<table>
<thead>
<tr>
<th>Pat Level</th>
<th>Type</th>
<th>Category</th>
<th>%</th>
<th>Amt</th>
<th>Time Period</th>
<th>Quantity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>Exclusions</td>
<td>Accident</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Define how Exclusions are billed in Family Module Preferences (637), or in the Insurance Plan (81), Other Ins Info tab.

9. Lifetime Max for Code or Category
For plans that have a lifetime maximum for certain codes or categories, create an Other Benefit to define the applicable code or category, and the amount.

<table>
<thead>
<tr>
<th>Pat Level</th>
<th>Type</th>
<th>Category</th>
<th>%</th>
<th>Amt</th>
<th>Time Period</th>
<th>Quantity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>Limitations</td>
<td>D6010SurgImpEnd</td>
<td>3,000</td>
<td></td>
<td>Lifetime</td>
<td></td>
</tr>
</tbody>
</table>
10. If You have different categories
Usually this means you are in a country other than the U.S. or Canada, and thus using Row View instead of Simplified View. Enter the insurance categories in Definitions(835) and Insurance Categories(683). Then assign benefit amounts. For a Canadian Time Unit benefit example, see Canada Procedure Code Time Units.

Deductibles
In the Edit Benefits(86) window, at the top right, is an area to enter Deductibles by category.

Sometimes the deductibles for specific Insurance Plan(81) Categories differ from the general deductible. Below are some common scenarios and how to set them up.

When the General Deductible does not apply to diagnostic or preventive care, enter 0.00 for both Diagnostic and Routine Preventive deductibles. This is the default.

When the General Deductible applies to diagnostic care but not preventive care, leave Diagnostic blank and enter 0.00 for Routine Preventive.
When the General Deductible applies to all care, leave all Deductibles (if different) fields blank.

When the diagnostic deductible is different than the general deductible and preventive work has no deductible, enter the deductible for Diagnostic and 0.00 as the deductible for Routine Preventive.

### Frequency Limitations

A procedure’s insurance frequency limitations may or may not affect estimates of treatment planned procedures, depending on your preferences.

In the **Edit Benefits** window, at the left, is the Frequencies section.

When insurance frequency checking is enabled:
- In the **Treatment Plan Module**, primary and secondary insurance estimates will consider frequency limitations.
- When checking for frequencies, we take tooth number, surface, and tooth range into consideration.
- When scheduling a procedure that has met its limitation, a warning will pop up.

**Example**: Frequency limitation for BWs is every 2 years. On 12/28/2016, patient had BWs taken and a claim was sent and received.

In the Treatment Plan Module:
• When the Estimate as of date is 12/29/2018 and later (2 years after completed procedure), BW estimates will indicate it is covered.
• When the Estimate as of date is 12/28/2018 or earlier (limitation already met), the BW estimate will indicate that the procedure is not covered by insurance.

When scheduling an appointment:
• If the schedule date is 12/29/2018 or later, scheduling proceeds as normal.
• If the schedule date is 12/28/2018 or earlier, a warning will pop up indicating a frequency conflict exists. You have the option to proceed or cancel.

---

**Set up and Enable Frequency Checking**

In [Treatment Plan Module Preferences](#), check *Enable Insurance Frequency Checking* and select the codes affected by each limitation. The defaults are:

- **BW**: D0272, D0274
- **Pano/FMX**: D0210, D0330
- **Exams**: D0120, D0150
- **Cancer Screening**: D0431
- **Prophylaxis**: D1110, D1120
- **Fluoride**: D1206, D1208
- **Sealant**: D1351
- **Crown**: D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794
- **SRP**: D4341, D4342
- **Full Debridement**: D4355
- **Perio Maintenance**: D4910
- **Dentures**: D5110, D5120, D5130, D5140, D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226
- **Implant**: D6010

Enter the plan’s frequency limitations on the Benefit window. Click *More* to add additional frequency limitations.

For each frequency limitation procedure code, a row will show in the Family module, Insurance Plan area.

**View Estimates for Treatment Planned Procedures**

In the Treatment Plan module, click the *Estimate as of* dropdown and select the date. Click Refresh to update calculations based on the date.
When a procedure is not covered due to a frequency limitation, the procedure's description will indicate it.

**Adjustments to Insurance Benefits**

Adjustments to Insurance Benefits is used when a patient uses benefits outside of your office.

In an [Insurance Plan](81), at the upper right, is the Adjustments area.

Click **Add** to create a new adjustment.

This adjusts the benefits used to reflect estimates properly in the Treatment Plan. Once the patient's benefit year is up, the amount entered will no longer affect estimates. It will remain listed for future reference.

Examples:
- The patient had treatment done at another office.
- You have just had a data conversion and need to account for prior claims that didn't convert.
Enter the adjustment information:

- **Date**: The date the adjustment is made. Make sure it falls within the correct benefit year.
- **Insurance Used**: The total amount of insurance used. Negative numbers are allowed to indicate rollover amounts available from previous year.
- **Deductible Used**: The deductible amount used.

Click OK to save.

**Note**: The insurance used will total all insurance adjustments added within the benefit year. For example, if a patient uses benefits outside the office on two separate occasions within their benefit year, you can add two separate entries in the insurance adjustments.

### Fields that Trigger New Plan

New plans can be created from an existing insurance plan.

In an [Insurance Plan](81), select *Create new Plan if needed*.

To create a new plan, ensure the radio button above is selected, and at least one of the following field values must change. This is useful when a plan changes for a subscriber, but not the other members on the plan.

The following fields are listed in order as shown on the insurance plan. (Top to bottom, each tab, then subscriber information.)

**Field = Db Column Name**

Medical Insurance = IsMedical
Employer = EmployerNum
Carrier Information = CarrierNum
Group Name = GroupName
Group Number = GroupNum
Plan Type = PlanType
Use Alternate Code = UseAltCode
Don't Substitute Codes = CodeSubstNone
Claims show for UCR fee = ClaimsUseUCR
Hidden = IsHidden
Fee Schedule = FeeSched
Claim Form = ClaimFormNum
Patient Co-Pay Amounts = CopayFeeSched
Carrier Allowed Amounts = AllowedFeeSched
COB Rule = CobRule
Filing Code = FilingCode
File Code Subtypes = FilingCodeSubtype
Claim show base units = ShowBaseUnits
Ortho Claim Type = OrthoType
Ortho Auto Proc = OrthoAutoProc
Ortho Auto Fee = OrthoAutoFeeBilled
Auto Proc Period = OrthoAutoProcFreq
Wait 30 days before creating first automatic claim = OrthoAutoClaimDayWait
Plan Note = PlanNote
Trojan ID = TrojanID
Benefit Year (Benefit Info window) = MonthRenew
Don't Verify checkbox = HideFromVerifyList

**Canadian Customers only:**
Div. No. = DivisionNo
Dentaide Card Sequence = DentaideCardSequence
Plan Flag = CanadianPlanFlag

---

**Electronic Eligibility and Benefits**
Eligibility requests retrieve benefit information from a Clearinghouse.

In the **Insurance Plan** window, in the middle, click **Request.**
Clearinghouses with Electronic Eligibility Services

There are several options, including:

- ClaimConnect (656) (DentalXChange). ClaimConnect can be used for both electronic benefits and e-claims.
- Electronic Dental Services (EDS) (666)
- Emdeon / ChangeHealthcare / WebMD (681)
- Trojan (1072)

Electronic eligibility and benefit information allows you to electronically verify a patient's insurance eligibility and benefits in real time (e.g. percentages, deductibles, maximums, limitations, and history). Non-subscriber benefits that are not identified as family coverage are inserted as patient override benefits.

Electronic Eligibility checks can be run as a batch by creating a Scheduled Process (810) for that purpose.

Dates: This grid shows information on eligibility and active service dates.

Mark for import if: Select whether benefits for In Network or Out of Network should be imported. Dependent on your disposition with the carrier.

Show Raw Message of...:
- Request: Click to display raw version of the benefit request message sent to your clearinghouse.
- Response: Click to see the raw response message sent by the clearinghouse. See example here:
Note: Open Dental tries to interpret each raw benefit and to provide an equivalent Open Dental benefit object in the right column. Any of these can be imported, but it still takes a human to interpret the data. Most carriers still send very sparse data, frequently nothing more than single yes or no response on whether the patient is covered.

**Response Benefit Information**: Grid of benefit details received from clearinghouse.
- **Response**: List of benefits reported by the clearinghouse. Will include both out of network and in network benefits. Use care in selecting which to import. See example below.

<table>
<thead>
<tr>
<th>Element</th>
<th>Raw</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>C</td>
<td>Deductible</td>
</tr>
<tr>
<td>2</td>
<td>IND</td>
<td>Individual</td>
</tr>
<tr>
<td>3</td>
<td>30</td>
<td>Health Benefit Plan Coverage</td>
</tr>
<tr>
<td>4</td>
<td>23</td>
<td>Calendar Year</td>
</tr>
<tr>
<td>5</td>
<td>100.00</td>
<td>$100.00</td>
</tr>
<tr>
<td>6</td>
<td>N</td>
<td>Out of network</td>
</tr>
</tbody>
</table>

- **Note**: Benefit note.
- **Import As Benefit**: Displays benefit this response will import as.
Import Benefit Coinsurance:
- **Carrier sends patient %**: Select if benefit response describes patient responsibility. This is the default.
- **Carrier sends insurance %**: Select if benefit response describes insurance portion.

**Current Group Num**: The entered group number on the selected patient. A red warning will display if this does not match the group number reported by the carrier below.

**Response Group Num**: The group number returned by the carrier.

**Import**: Click to import selected response benefits to the patient's plan.

**Current Benefits**: A list of current benefits entered in on the selected patient's insurance plan.

**Note**: Use to record notes as desired when importing benefits.

**Setup**
1. Register with the vendor. If a clearinghouse, make sure Real Time Eligibility or real time services is enabled.
2. If a clearinghouse, set the clearinghouse as your default dental clearinghouse. See Clearinghouses (645).
   - **Note**: If Trojan, enable the bridge. Then click Trojan on the Edit Insurance Plan window.
3. Verify that each carrier's electronic ID is entered accurately in Open Dental (Insurance Plan (81) or Carriers (1237)). To determine a carrier's electronic ID, check with the clearinghouse.

**View Request History**
On the **Edit Insurance Plan** (124) window, click **History**. All requests and responses are stored for future reference.

**Technical Information**
In order to improve the automation in Open Dental, we are interested in seeing any situations where Open Dental could automatically interpret the benefits better. Especially long and complex responses. If the carrier returns a percentage breakdown by category, Open Dental should be able to easily import those percentages. If it can't we would like to see the response so we can improve the automation. Please contact technical support if you are willing to provide this information. The raw 271 response is accessible at the upper right of the Edit Electronic Benefit Request window.

Toggle between the Mark for import if... radio buttons to quickly mark all the in or out of network benefits for import. Only marked benefits will be imported when the Import button is clicked. Some benefit types that Open Dental does not yet import include:
- **Addresses**
- Dates
- Co-pays
- Group names/numbers

Importing these types is considered a Feature Requests (1636). Our goal with this initial implementation is to get benefit information such as percentages, deductibles, maximums, limitations, and of course, eligibility.

Troubleshooting
Error message: There is a problem with your benefits request. Check with your clearinghouse to ensure they support Real Time Eligibility for this carrier and verify that the correct electronic ID is entered.
Solution: Your clearinghouse may not support Real Time Eligibility for the carrier or the electronic ID entered in Open Dental for the carrier may be inaccurate.
- Contact the clearinghouse to check on the carrier's Real Time Eligibility status.
- Verify that the carrier's electronic ID is entered accurately in Open Dental (Edit Insurance Plan (124) window or Edit Carrier (1237) window). To determine a carrier's electronic ID, check with the clearinghouse.

Error Message: ...Error message received directly from Claim Connect: Deficient request - required data is missing.
Solution: Double check that all provider information in the Edit Provider (1255) window is entered correctly.

Carestream Discount Plan
If you need to setup a Carestream like discount insurance plan, here are the steps:

In the Edit Insurance Plan (81) window, select these options:
- Plan Type: PPO Percentage
- Fee Schedule: The Carestream fee schedule.
- Benefit Information: zero out all coverage.

The estimate will show your UCR fees and the writeoff. The balance will be the patient's portion.

If you want to only show the patient's portion with no writeoff, change the plan type to Category Percentage.

Add Insurance
In the Family Module (59) toolbar, click Add Insurance.

Subscriber
Always enter insurance plan information for the subscriber before separately assigning the plan to non-subscriber family members.

Non-subscriber
Note: Many insurance carriers have switched to each patient being their own subscriber. In that case, you would not enter any non-subscriber family members.

Double-click the subscriber to select, or click More Patients to select any patient in the database.

**Select Insurance**

If there is already existing insurance, you will be given a chance to select it.

It gives you the chance to pick an existing plan or to create a new plan.

Note: Security permission *PatPlanCreate* is used to log an entry in the when a new patient insurance plan is created.

**Edit Insurance Plan**

Once in the Insurance Plan(81) window, at the top middle, you can use the Pick From List button to select an existing plan from the Insurance Plans(1244) list. At a minimum, select the patient's Relationship to Subscriber.
Insurance Plan Types

Different types of Insurance Plans require different settings. When entering insurance plan information, there are four different plan type options and several areas that affect fee schedules.

The links below explain which plan types to use for different insurance plan scenarios and how to set fee schedules and other settings.

- **PPO Insurance Plan**: Can track write-offs.
- **PPO Fixed Benefit Insurance Plan**: Insurance covered at fixed amount. Tracks write-offs.
- **Category Percentage Insurance Plan**: With fee schedules or without.
- **HMO / DMO Insurance Plan with Co-pays** (e.g. Texas plans): Track write-offs.
- **Medicaid or Flat Co-Pay Insurance Plan**: 100% coverage (no percentages, maximums or deductibles). Doesn't track write-offs.
- **Capitation (HMO / DMO) Insurance Plan**: Office receives a flat fee every month. Patients may pay a flat fee for some procedures and no fee for others.
- **Discount Plans**
- **Per Visit Co-Pays**
- **Insurance Plan with Different Coverage Levels** (e.g. Incentive Plans)

### PPO Insurance Plan

This is an In-network / Contracted Insurance Plan Type. PPO stands for Preferred Provider Organization. Set up this Insurance Plan Type when you are contractually obligated to reduce your fees as an in-network provider. Because you are enrolled with the insurance company, you have access to a published list of fees that you must charge the patient. The insurance portion is calculated as a percentage of the published fee and the patient pays the rest.

There are two setup options: one tracks write-offs, the other doesn't. Write-offs are the difference between the contracted fee and the provider's UCR fees.

- **Note**: If a patient has both primary and secondary insurance and you want benefit estimates to be more accurate, you must set both up as PPO Percentage (Option 1).
- To set up a plan that has co-pays and makes supplemental payments (mixed capitation), see HMOs/DMOs with Supplemental Payments and Copays (121) instead.
- To see how the fee schedule is determined, see Fee Schedule Logic (1209).

### Option 1: Set up a PPO plan and track write-offs

Set up an insurance plan with a PPO Percentage plan type and the carrier fee schedule. This plan tracks write-offs.

On the Insurance Plan(81), select these options:
- **Plan Type**: PPO Percentage
- **Fee Schedule**: The carrier's Fee Schedules(914).
Insurance estimates will be based on the carrier's fee schedule.

Procedure fees will be based on the provider's fee schedule.

Write-offs are usually calculated using the following formula: \( \text{UCR fees} - \text{PPO fee} \) The difference between the two amounts will be an automatic write-off.

Typically, if the PPO fee is higher than a provider's UCR fee, the PPO fees are used as the billed fees. To instead use the UCR fees, see Account Module Preferences(693).

You don't have to check the **Claims show UCR fee, not billed fee** because the provider's UCR fees already show on claims. The correct insurance estimate (breakdowns) will show in the account after the claim is created.

Write-offs are reported in Production and Income reports, the Daily Write-off report, the PPO Write-offs report, and the Receivables Breakdown report.

**Option 2: Set up a Category Percentage plan and don't track write-offs (NOT RECOMMENDED)**

This is a simpler approach for an in-network plan but doesn't track write-offs. It is not recommended for a few reasons:
- It does not work with electronic EOBs (ERAs).
- If fees schedules are incorrect, patients will be billed incorrectly which could lead to lower collection rates.
- At risk of not getting full reimbursement from insurance. Submitting the full office fee is the only way to get maximum reimbursement.
- It is harder to manage and identify insurance overpayments.

Set up an insurance plan with a Category Percentage plan type and the carrier fee schedule. The carrier fees will be used instead of the provider's fees. One disadvantage is that patients will not see the provider's fees and may not be aware that a discount is being given.

On the Edit Insurance Plan window, select these options:
- **Plan Type**: Category Percentage
- **Fee Schedule**: The carrier's fee schedule.
- (optional) To show the provider's fees on the insurance claim, check **Claims show UCR fee, not billed fee** in the Other Ins Info tab.

**Patient Co-pays for Procedures**

If the patient is required to co-pay for procedures, follow these steps.

1. Create a **copay** fee schedule for the carrier.
2. For each procedure code, enter the patient's copay amount. There can be just a few fees with the rest blank. If you only have the insurance copay fee schedule, not the patient copay amounts, use this equation to obtain the fee:

\[ \text{Carrier Fee} - \text{Insurance CoPay} = \text{Patient CoPay} \]

3. On the Edit Insurance Plan window set the following:
   - **Fee Schedule**: The carrier's normal fee schedule.
   - **Patient Co-pay Amounts**: The carrier's copay fee schedule.

**Benefits** (86): Usually you will set all percentages to 100% so that everything above the copay is calculated as the insurance portion. If you do not set percentages to 100%, percentage calculations will be performed on the remaining amount.

**PPOs with fee schedules that change after first year**

These can be easily handled by using two insurance plans: one for preventive services, and one for basic services. These will need to be updated manually after the first year so that estimates etc. are monitored closely during the transition to the second year, when benefits will have to be updated in Open Dental.

**PPO Insurance Calculations**

Below is an explanation of the math behind write-offs, covered amounts, insurance estimates, and patient portion for PPO Insurance Plan (114).

Sample fees:
- Office Fee = $150
- PPO Fee = $127
- Deductible = $50
- Covered Percentage = 80%

**Write-off**: The difference between your office fee and contracted PPO fee.

\[ \text{Office Fee} - \text{PPO Fee} = \text{Write-off} \]

$150 - $127 = $23

**Covered Amount**: Subtract the deductible from the PPO fee (before applying the covered percentage).

\[ \text{PPO Fee} - \text{Deductible} = \text{Covered Amount} \]

$127 - $50 = $77

**Insurance Estimate**: Apply the covered percentage to the covered amount.

\[ \text{Covered Amount} \times \text{Covered Percentage} = \text{Insurance Estimate} \]

$77 \times 80\% = $61.60

**Patient Portion**: Subtract the insurance estimate amount and write-off from the office fee.

\[ \text{Office Fee} - \text{Write-off} - \text{Insurance Estimate} = \text{Patient Portion} \]

$150 - $23 - $61.60 = $65.40
**Downgrades**
In this example we will explain the math behind a two surface downgrade. For posterior composites, most companies still base their payment calculations on the corresponding amalgam code for the same number of surfaces.

**Sample Fees**
- Office Fee for D2392 = $150
- PPO Fee for D2392 (composite) = $127
- PPO Fee for D2150 (amalgam) = $100
- Deductible = $50
- Covered Percentage = 80%

**Write-off:** The billed code is always used for the PPO fee, so for a downgrade it uses the PPO fee for D2392 (composite). This is the last time the D2392 PPO fee is used.
Office Fee - PPO Fee = Write-off

\[ $150 - $127 = $23 \]

**Deductible:** Subtract the deductible from the PPO Fee for D2150 (amalgam),

\[ \text{PPO Fee} - \text{Deductible} = \text{Covered Amount} \]

\[ $100 - $50 = $50 \]

**Insurance Estimate:** Apply the covered percentage to the covered amount.

\[ \text{Covered Amount} \times \text{Covered Percentage} = \text{Insurance Estimate} \]

\[ $50 \times 80\% = $40 \]

**Patient Portion:** Subtract the insurance estimate amount and write-off from the office fee.

\[ \text{Office Fee} - \text{Writeoff} - \text{Insurance Pay} = \text{Patient Portion} \]

\[ $150 - $23 - $40 = $87 \]

For more information about downgrades, see [Estimate Downgrades](137).

**PPO Fixed Benefit Insurance Plan**
Set up a PPO Fixed Benefit [Insurance Plan Type](114) when you are contractually obligated to reduce your fees as an in-network provider and the insurance plan is paying a fixed amount.

This insurance plan type calculates write-offs, includes the insurance portion, and rolls the remaining amount to the patient.

On the [Insurance Plan](81), set the following:
- **Plan Type:** PPO Fixed Benefit
- **Fee Schedule:** The carrier’s fee schedule.
- **Fixed Benefit Amounts:** The plan’s fixed fee schedule ([Fee Schedules](914), FixedBenefit).
Note: The Fixed Benefit Amount box will only show if the Plan Type is set to PPO Fixed Benefit. A Fixed Benefit fee schedule is required.

This plan will set all insurance categories to 100% coverage. Insurance estimates come directly from the Fixed Benefit fee schedule.

The patient portion is calculated using the following formula: \( \text{UCR fee} - \text{Write-Off} - \text{Fixed Benefit amount} \)

Write-offs are usually calculated using the following formula: \( \text{UCR fee} - \text{PPO fee} \). The difference between the two amounts will be an automatic write-off.

Note: Write-offs are reported in Production and Income reports, the Daily Write-off report, the PPO Write-offs report, and the Receivables Breakdown report.

If the PPO fee is higher than a provider's UCR fee, the PPO fees are used as the billed fees. To instead use the UCR fees, see Account Module Preferences.

To set how blank fixed benefit fee schedules are handled, see Family Module Preferences, Fixed benefit fee schedules treat blank entries as zero.

You don't have to check the Claims show UCR fee, not billed fee because the provider's UCR fees already show on claims. The correct insurance estimate (breakdowns) will show in the account after the claim is created.

**Category Percentage Insurance Plan**

Set up an out-of-network Insurance Plan Type when you are NOT contractually obligated to reduce your fees. This is a traditional percentage insurance plan.

**Out of Network Plan with No Fee Schedule**

In this setup, estimates and procedure fees will be based on the provider’s fee schedule.

On the Insurance Plan, set the following:
- **Plan Type**: Category Percentage
- **Fee Schedule**: none (uses the provider's default fee schedule).

**Out-of-Network Plan with a Fee Schedule**

Even if you are not contractually obliged to follow out-of-network fees, you can get more accurate insurance estimates by using them.

1. Create an out-of-network Fee Schedule for the carrier and enter the out-of-network fees.
2. On the Edit Insurance Plan window, set the following:
   - **Plan Type**: Category Percentage
   - **Fee Schedule**: none (uses the provider’s default fee schedule).
   - **Carrier Allowed Amount**: The carrier's out-of-network fee schedule.
In the Other Ins Info tab, check **Claims show UCR fee, not billed fee.**

**Benefits**: Percentages will be based on the out-of-network fee schedule. If the published fee schedule shows exact amounts that will be paid, set category percentages to 100%.

All fees on procedures will show the provider's fees, but the out-of-network fee schedule will be used for estimates. Percentages will be based on the out-of-network fee schedule. The patient is still responsible for amounts your office charges above the published fees. If desired, you can update out-of-network fees as you enter claims and payments.

### Medicaid or Flat Co-Pay Insurance Plan

Set up this **Insurance Plan Type** when the plan pays a flat fee instead of a percentage. Insurance coverage will be 100%.

Write-offs are not tracked and production numbers may be inflated. To track write-offs, see **HMO / DMO Insurance Plan with Co-pays**.

On the **Insurance Plan**, select these options.

- **Plan Type**: Medicaid or Flat Co-Pay. This will clear all percentages, maximums and deductibles, but a warning message will show first.
- **Fee Schedule**: The carrier's fee schedule.
- **Patient Co-pay Amounts**: The co-pay fee schedule for the carrier.

If insurance does not cover a procedure for some reason, and you don't expect the patient to pay, you can enter it as a write-off when you enter the insurance payment, however these write-offs are not tracked.

If a patient is required to pay a co-pay for procedures
1. Create a co-pay **Fee Schedule** for the carrier.
2. For each procedure code, enter the patient's co-pay amount. There can be just a few fees with the rest blank. If you only have the insurance co-pay fee schedule, not the patient co-pay amounts, use this equation to obtain the fee:

   \[
   \text{Carrier Fee} - \text{Insurance Co-Pay} = \text{Patient Co-Pay}
   \]
Capitation (HMO / DMO) Insurance Plan

Capitation is also known as HMO/DMO. Set up this Insurance Plan Type (114) when you receive a flat fee every month, regardless of what work is done on the patients.

![Plan Type and Fee Schedule](Image)

Patients pay a flat fee for some procedures and no fee for other procedures. Sometimes, a fee for the lab portion can be billed to insurance.

Note: To show Capitation as an option on the Edit Insurance Plan window, check Capitation in Show Features (806). To set up a plan that has co-pays and makes supplemental payments (mixed capitation), see HMO / DMO Insurance Plan with Co-pays (121) instead.

Set up the Plan

1. For any patient portions, set up a co-pay Fee Schedule (914). For each procedure code enter the fee the patient must pay.

2. On the Insurance Plan (81), set the following:
   - Plan Type: Capitation. All benefit percentages will clear.
   - Fee Schedule: none. The provider’s UCR fees will be used in the Treatment Plan and in the Account, but will not affect the patient’s balance when procedures are complete.
   - Patient Co-Pay Amounts: The new co-pay fee schedule.

Billing Insurance

If you need to bill insurance (rare)

1. In the Account Module, select the procedure and click New Claim.
2. On the Edit Claim window, double-click on the procedure. Click OK when prompted.
3. Change the Fee Billed to Ins amount to the amount the carrier is required to pay.
4. Change the Insurance Estimate to the same amount.
5. Click OK, then send the claim. If you do not expect to apply a payment for the claim, then mark the claim as received so it does not show on the Outstanding Insurance Claims report.

Because the claim is for a capitation insurance plan, the amount expected from insurance will not be applied to the patient balance.

When you receive the monthly payment from the carrier, do not enter the payment in the claim. Instead, record the payment in a dummy patient for the carrier:

1. Create a dummy patient with the same name as the carrier.
2. Apply all payments to that patient. You have a few options:
   - Option 1: Apply as patient payments to dummy patient with carrier name. If Enforce Valid Paysplits (693) is set to Auto-Split Only or Don’t Enforce, allocate the pay splits to a specific provider by editing the pay split. If Enforce Valid Paysplits is set to Enforce Fully, the pay splits will be tracked as unearned income.
   - Option 2 (Enforce Valid Paysplits settings can be Enforce Fully, impacts production): Another option is to add a capitation payment procedure for the full payment amount, however this will impact production values.
Option 3 (if you must have payments show as insurance payments): Apply as insurance payments so they show on your reports and deposit slips as insurance payments.

1. Add the capitation insurance plan to the dummy patient.
2. Create a dummy procedure with no fee.
3. Create a dummy claim with at least one procedure and 0 fee.
4. Enter the first payment by total. Each time you receive a payment, add the new payment By Total on the same claim (not to the actual patient's claims)

We do not recommend having more than one capitation plan for a single patient. If you do so, you must manually change the secondary capitation plan’s write-off amounts for each procedure and Open Dental reports will give incorrect production numbers. To fix production numbers, run Query #911, then delete any duplicate CapCom status insurance estimates so that there is only one CapCom estimate for each procedure.

Also do not manually add insurance estimates with a CapCom status; they are created automatically. If you have duplicates, production numbers will be inaccurate. To fix production numbers, run Query #911, then delete any duplicate CapCom status insurance estimates so that there is only one CapCom estimate for each procedure.

Reports
Run the Capitation Utilization Report(1313) at the end of each month to show all procedures for a date range performed for capitation, along with the provider fees and the patient co-pay.

Production and Income Reports(1281) include production from capitation as Procedure Fee - Capitation Write-offs (as part of the (gross) Production column). For most procedures this contribution is $0, but if there is a patient portion (copay) then the capitation write-off will be less than the fee and thus the patient portion is part of the production.

Aging of Accounts Receivable (A/R) Report(1308): Capitation payments entered under a dummy patient will reflect as credits in the A/R report. This can be avoided by using a billing type that is excluded when running the A/R report.

Technical Details
Internally, a capitation claim creates a second claim procedure.

- The first claim procedure has a status of CapComplete and contains the procedure write-off.
- The second claim procedure has a status of CapClaim and is only used to show the procedure detail for the claim. The status will not change when the claim is received.

Payment entry on individual capitation claims would be a feature request.

HMO / DMO Insurance Plan with Co-pays
Also known as mixed capitation, this Insurance Plan Type(114) is used for HMOs or DMOs with supplemental payments and co-pays.
It tracks write-offs and is common in Texas (e.g. CHIP, MCNA, DentaQuest, Medicaid).

Create a PPO plan that tracks write-offs, then add a co-pay fee schedule.

1. Create a normal Fee Schedule (914) for the carrier. To calculate the fee for each procedure, add the insurance supplemental amount to the patient co-pay. ("Insurance Supplemental Amounts + Patient Co-Pay = Procedure Fee").

2. Create a co-pay fee schedule for the carrier, then for each procedure enter the patient co-pay.
   Note: If there is no fee, make sure to enter 0 or the patient will get charged the UCR fees (or set the blank entry default behavior in Family Module Preferences (637)).

3. On the Insurance Plan (81), set the following:
   - **Plan Type**: PPO Percentage
   - **Fee Schedule**: The carrier's normal fee schedule.
   - **Patient Co-Pay Amounts**: The carrier's co-pay fee schedule.
   - **Benefit Information**: Set benefits to 100% for all categories.

Example: For Procedure A, DMO Insurance’s will pay $90 and the patient has a co-pay of $10.
- In the normal fee schedule, Procedure A will have a fee amount of $100 (insurance + co-pay).
- In the co-pay fee schedule, Procedure A will have a fee of $10 (the co-pay).

To calculate insurance estimates, Open Dental uses the following equation:

\[
\text{Procedure A normal fee ($100) - Procedure A co-pay fee ($10) = Insurance estimate ($90)}
\]

**Troubleshooting**

If you entered this kind of plan as a Capitation plan type with a co-pay fee schedule, follow these steps to fix it.

1. In the Main Menu (592), click Setup, Fee Schedules. Add a normal fee schedule with a similar but not identical name to the existing co-pay fee schedule.

2. For each procedure in the normal fee schedule, enter the fees using the following equation to determine the amount:

\[
\text{(Patient Co-Pay + Insurance Supplemental Amounts = Procedure Fee)}
\]

Make sure to enter 0 for all fees where there is no supplemental fee or co-pay.

3. On the Edit Insurance plan window, change the following:
   - **Plan Type**: PPO Percentage (from Capitation).
   - **Fee Schedule**: The new normal fee schedule.
   - **Benefit Information**: Set benefits to 100% for all benefit categories.

---

**Per Visit Co-Pays**
For Patient Insurance Plan Types (114) that require a co-pay per visit rather than per procedure, follow these steps to set up the plan:

1. Create a new non-D procedure code called office visit or something similar. Check the Do Not Usually Bill to Insurance box. See Add Procedure Code (1204).
2. Set up a co-pay fee schedule. See Fee Schedules (914).
3. If the carrier's fee schedule is normal (in-network), enter the co-pay as the fee for the procedure code in both the carrier and the new co-pay fee schedules.
   
   If the carrier's fee schedule is out of network, enter the co-pay as the fee for the procedure code in the carrier, the new co-pay, and the UCR (office fees) fee schedules. In this scenario you may need to create a different procedure code for each carrier.

4. On the Insurance Plan (81), for Patient Co-Pay Amount select the co-pay fee schedule.
5. Add the new procedure code (office visit) to each scheduled appointment for patients with this insurance.

Feature request #2073 would make this process take less steps.

Insurance Plan with Different Coverage Levels

Certain Insurance Plan Types (114) provide different coverage levels per patient on the plan.

In Other Benefits (94), click Add.

Examples:

- Incentive plans: First year of coverage: 70%. For each year after, coverage increases by 10%.
- Adults or subscribers covered at a different level than children or dependents.
To start, enter the insurance plan for the subscriber with the subscriber's benefit information, and add the insurance plan to other family members (non-subscribers).

For family members that have a different coverage level, add an Other Benefit.
1. Check **Patient Override**.
2. Select the category affected.
3. Enter the percentage covered for this year.
4. Select a Coverage Level of Individual.
5. Click OK.

In the benefit grid this benefit row will have an X in the Pat column to indicate it applies to this patient only. In this example, restorative procedures for this patient are only covered at 50%.

<table>
<thead>
<tr>
<th>Pat</th>
<th>Level</th>
<th>Type</th>
<th>Category</th>
<th>%</th>
<th>Amt</th>
<th>Time Period</th>
<th>Quantity</th>
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</thead>
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<td>Individual</td>
<td>%</td>
<td>Restorative</td>
<td>50</td>
<td>CalendarYear</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Change Insurance Plan Information**

When a patient's Insurance Plan information or benefits change, updates also need to be made within Open Dental. The steps to take depend on the scenario.

If a patient has a brand new plan, employer, carrier, etc., we recommend dropping the plan, not changing an existing plan. Dropping a plan will not change historical information, but changing plan information can. If in doubt, drop the plan, don't change it. See [Drop Insurance Plan](#).

Note: When editing plan information via the Insurance Plan Edit Window, always make sure the correct radio button for **create** or **change** is selected.

Create new plan if needed: When Fields that Trigger New Plan are changed, a brand new plan is created.

Change plan for all subscribers: Changes, limited to Fields that Trigger a New Plan (linked above), will change for all subscribers.

**Change Employer Name**

If an employer's name changes, update it via the Employers List. It will be updated for all patients with the plan.
1. In the Main Menu, click Lists, Employers.
2. Double click the employer to open the Edit Employer window.
3. Change the name.
4. Click OK to save.

Note: If employer information is changed from within the Edit Insurance Plan window, a new employer is created.

**Change Carrier Information (e.g. address, phone)**

Always change carrier contact information via the Carriers List. It will be updated for all patients with the plan.
1. In the main menu, click Lists, Insurance Carriers.
2. Double click the carrier to open the Edit Carrier window.
3. Change the details.
4. Click OK to save.

Note: If carrier information is changed from within the Edit Insurance Plan window, a new carrier is created.
Change Plan Information for All Subscribers
When multiple subscribers have the same plan, you can change plan information for all subscribers at once. Usually this is only done when plan information is incomplete or inaccurate. Most changes will not affect historical estimates or claims. Changes can be made via the Insurance Plans List or from a subscribing patient's Edit Insurance Plan window.

Note: If there is a new carrier for all subscribers on a plan, do not just change the carrier for all subscribers because this will affect historical claims. Instead create a new plan, then move subscribers to the new plan.

From the Insurance Plan List:
1. In the main menu, click Lists, Insurance Plans.
2. Double click the insurance plan to open a modified version of the Edit Insurance Plan window (Only Insurance Plan and Benefit Information shows).
3. Change any insurance plan information or benefit percentages.
4. Click OK to save.

From a subscribing patient:
1. Select the patient.
2. In the Family module, double click the insurance plan to open the Edit Insurance Plan window.
3. Make sure Change plan for all subscribers is selected.
4. Change any insurance plan information or benefit percentages.
5. Click OK to save.

Change Plan for a Single Subscriber
Follow these steps to change plan information and/or benefits for one subscriber only. These steps will create a new insurance plan.

Note: If there is a new carrier, do not just change the carrier because this will affect historical claims. Instead drop the old plan then create a new plan.

1. Select the patient.
2. In the Family module, double click the insurance plan to open the Edit Insurance Plan window.
3. Select the Create new Plan if needed radio button.
4. Change the insurance plan and benefits as needed.
5. Click OK to save.

Move Subscribers from One Plan to Another Plan
Moving subscribers is useful at the beginning of a benefit year when insurance plans may change for a group of subscribers. It will move subscribers of one plan to another plan, and drop the old plan. The move is irreversible. See Move Subscribers (1411).

Check/Change Fee Schedule Assignments for Multiple Insurance Plans
Use the Check Ins Plan Fee tool to check which fee schedules are assigned to insurance plans and, if needed, quickly change the assigned fee schedule. Fee schedules can be changed for multiple plans at once. See Check Ins Plan Fees (916) for more detailed steps and the password that is required.

1. In the main menu, click Setup, Fee Schedules.
2. Next to Check Ins Plan Fee Schedules, click Go.
3. Review the fee schedules used by each plan.
4. Select the insurance plan(s) to assign a new fee schedule.
5. Click the New Fee Schedule dropdown to select the new fee schedule.
6. Click Change to change the fee schedule for all selected insurance plans. A password is required.
Drop Insurance Plan

In an Insurance Plan (81), at the upper left, click Drop.

Dropping an Insurance Plan (81) removes the plan from the selected patient only. Historical information is not affected, and the plan will still exist in the Insurance Plans (1244). The plan will no longer show in the patient's insurance area. It will, however, still show on the family's Insurance Plans for Family list, and you can click the Add Insurance (112) drop down to see it.

To re-add a dropped plan, in the Family Module (59), click Add Insurance. If the patient is the subscriber, click Yes. If not, click No, then select the subscriber.

Double click the dropped plan to select it. The dropped plan is indicated with (not in use).

Verify the patient information, insurance plan information, subscriber information, and benefit information, then click OK to save.

Combine Insurance Plans

In the Main Menu (592), click Lists, Insurance Plans (81).
Only combine plans as a cleanup measure. Multiple entries of an insurance plan in the list will not harm data. However, if you have duplicate plans that were inadvertently created when entering plan changes, combining can be useful.

Warning: Before combining, always make sure the plans are really duplicates. Combining is a permanent, irreversible change that will affect historical data on claims. Ask yourself:

- Should the plans be combined? Verify that employer, group #, group name, plan details, plan notes, and benefit percentages are all the same.
- Is there a good reason one plan is different? We recommend documenting reasons in the plan notes.
- Which plan has the most recent, accurate information (and will be kept)? Only one plan’s details and benefit percentages will be kept. Make sure you are confident when choosing the plan to keep.
- Which plans will be combined into the kept plan?

Note: Other benefits marked as a patient override will not be lost when combining plans.

If you determine that multiple instances of the same plan have been created by mistake, and want to clean up the list, follow these steps to combine them.

Review each plan’s details and benefits to determine which insurance plan you will keep and which plans will be combined into the keep plan.

Select the plans to combine. Click and drag or press Ctrl while clicking to select multiple.

Click Combine.
Highlight the one insurance plan that will be kept. Only this plan's details and benefits will be kept.

Click OK to combine.

All other plans will no longer appear in the list.

**Medical Insurance**

Open Dental has features for medical insurance, making it useful in oral surgery and hospital settings.

Turn on Medical Features: In the **Main Menu** (592), click Setup, Advanced Setup, **Show Features** (806), then select **Medical Insurance**. Restart Open Dental for the change to take effect.

**Insurance Plans**

Patients can have unlimited insurance plans. To designate an insurance plan as medical, select the following on the **Insurance Plan** (81).

- Check the Medical Insurance box. This will identify the plan as medical instead of dental.
- Select the claim form for the plan.
  - **HCFA 1500 Claim Form** (645): If printed, must use preprinted forms due to its red background. They do not allow printing the background from a printer.

The new 1500 Health Insurance Claim Form (version 02/12) is included in version 14.2 and named 1500_02_2012. 1500 is the old version of the form. To reassign the new 1500_02_2012 claim form to insurance plans currently using the old 1500, see **Claim Forms** (641), Reassigning Claim Forms.
**Medical Procedure Codes**

**Cross Code** (734) medical codes to procedure codes

**Procedures**

Medical information can also be entered on the Procedure - Medical Tab (314).

- Medical Code: This box is filled in automatically when the procedure code is cross coded to a medical code.
- ICD Diagnosis Codes: Multiple ICD-10 codes can be used in conjunction with procedure codes. When attached to a procedure, one procedure for each visit needs to have Principal Diagnosis checked.

Note: To update to ICD-10 codes, see **ICD-10 Codes** (129).

- E-claim Note: Required for medical procedures ending in 99.

**Claims**

Create medical claims in the Account module. See **Claim Types** (228) for details on how insurance setup affects claim type.

- Select the procedures, then click the New Claim dropdown, Medical.
- If procedure codes are cross coded to medical codes, the medical codes will be sent.
- Change the Med/Dent or Claim Form settings on the **Claim** (208).

**E-Claims**

Use **Change Healthcare Medical E-Claims** (667) for medical claims.

- Medical vs Institutional: There are two formats for medical e-claims, medical (837-P) or institutional (837-I). The default is medical. To change, see **Account Module Preferences** (693), Set medical claims to institutional when using medical insurance. The type can also be changed on individual claims (Edit Claim window, Med/Dent).
- **Clearinghouses** (645): Set the default medical/institutional clearinghouse (separate from the dental default). Dental clearinghouses cannot accept medical or institutional claims. If you will generate claim files from Open Dental and upload them manually to Medicaid, you still need to set up a clearinghouse to specify the Claim Export Path. Medical and institutional claim format will be only 5010. Dental claim format can be 4010 or 5010 and you can freely switch as needed.
- **Send Claims**: Send batches of claims to one clearinghouse at once. See **Send Claims** (489).

Note: To determine the format, information is required from both the claim, MedType and the clearinghouse, Eformat. Neither alone is sufficient.

Once messages are generated, they are archived in the etrans table in the database for later retrieval. These archived claims may be seen in the history list at the bottom of the Insurance Claims window. All 4 claim types (med5010, inst5010, dent5010, dent4010) will show as claim sent in the archival.

**ICD-10 Codes**

Diagnosis codes can be sent with procedure codes (e.g. for Medical Insurance (128)). If you need to attach ICD-10 diagnosis codes to procedures, first download the code system, then assign the code.

Diagnosis codes can also be used for EHR.

October 1, 2015: ICD-10 codes are required for HIPAA covered transactions. See **CMS.gov ICD-10**.
ICD-10 codes are an updated version of ICD-9 codes. The current ICD-10 download is for 2019. When updating to ICD-10 codes, first download the ICD-10 code system, then change the default settings to use ICD-10 codes (instead of ICD-9). The code system for procedures already created (treatment planned or completed) will not change.

ADA.org ICD-10 FAQ.

**Download Codes**

<table>
<thead>
<tr>
<th>Download ICD diagnosis codes is optional.</th>
</tr>
</thead>
<tbody>
<tr>
<td>For problems, the codes must be downloaded then chosen from a pick list.</td>
</tr>
<tr>
<td>For procedures, codes can be manually entered or downloaded then chosen from a pick list.</td>
</tr>
</tbody>
</table>

Download or update ICD code systems using the [Code System Importer](#). You can open the importer via the main menu, Setup, Chart, EHR, Code System Importer, or on the ICD9/10 window click Import. Highlight the code system (e.g. ICD10CM), then click Download Updates.

**Default ICD Code System**

Set diagnosis coding system defaults in [Chart Module Preferences](#):

| Set the default code system under Use ICD-10 Diagnosis Codes (uncheck for ICD-9). |
| Set a specific default diagnosis code for new procedures. This code will show as the first diagnosis code on the Procedure - Medical Tab. |

Set the code system for a specific procedure on the Procedure Info - Medical tab by checking or unchecking *Use ICD-10 Diagnosis Codes (uncheck for ICD-9)*. The field labels for diagnosis codes will change to reflect the setting.

**Assigning Codes**

For Problems: Attach codes on the [Problem Def Edit](#) window. Click the pick list button [...] to select.

For Procedures: Attach codes on the Procedures - Medical tab. Enter the code(s) manually or click a pick list button [...] next to Diagnosis Code 1, 2, 3, 4.

If choosing from a pick list, at first the list will be empty. Enter the first few characters of the description or code, then click Search. To see all diagnosis codes, leave the code and description blank, then click Search.
Double-click the code to select it and close the window.

Troubleshooting Procedure Fees and Insurance Estimates

Many elements contribute to the calculation of procedure fees and insurance estimates. If treatment plan or procedure estimates are inaccurate, below are some troubleshooting hints.

**Fee Schedules**

Fee schedule can be set in several places and certain settings override others. See Fee Schedule Logic (1209) for an explanation of how a patient's fee schedule is determined.

- **Insurance Plan (81), Fee Schedule**: Make sure the correct one is attached. If using the default fee schedule of the provider, the selection should be none.
- **Insurance Plan (81), Other Fee Schedules**: This is where co-pay and out of network (allowed) fee schedules are assigned.
- **Provider (1255), Fee Schedule**: The default fee schedule of the provider. Typically this fee schedule applies to patients who have no insurance or if a patient has an Insurance Plan with none selected for Fee Schedule.
- **Edit Patient Information (62), Fee Schedule (rarely used)**: Only patients with a discount fee schedule should have a fee schedule selection here (e.g. cash only or Membership Plan). In most cases you will use the provider or insurance plan fee schedule.
If you recently updated a fee schedule, you may need to update fees.
- **Global Update:** In Fee Tools (1210), click **Update** to apply fee changes to all treatment planned procedures at once.
- **By Treatment Plan:** In the Treatment Plan Module (283), click **Update Fees** in the toolbar. This will update fees for the selected patient only.

### Insurance
Below are items to check.
- Insurance plan order in the Family module.
- Fee schedule assigned on the Edit Insurance Plan window (see above).
- **Insurance Plan Types** (114)
- Provider's fee schedule (Edit Provider window).
- Are there fees in the fee schedule? **Procedure Codes** (1195)
  - **Benefits** (86)
    - Percentages
    - Deductibles
    - Maximums
    - **Frequency Limitations** (104)
  - **Estimate Downgrades** (137): By default, Open Dental automatically downgrades posterior composite fees to amalgam fees if:
    1. The composite procedure code has an amalgam substitute code.
    2. There is a fee listed for the amalgam procedure in the fee schedule. To change the default, check the Don't Substitute Codes on the Edit Insurance Plan window.
- For PPO: In the Procedure Code List check or compare procedure fee amounts in fee schedules.
- Is a fee schedule assigned to the patient on the Edit Patient Information window (Fee Schedule (rarely used)).

Claims already paid will affect insurance remaining. See **Insurance Remaining Calculations** (295) for more details about how remaining insurance amounts are calculated.

To see an example of the math behind downgrades, see **PPO Insurance Calculations** (116).

### Secondary Insurance
The **Insurance Plan** (81) listed second in the **Family Module** (59) (order = 2) is considered secondary insurance.

### Creating Secondary Claims
In the **Account Module** (150), click New Claim and verify claim information. When you click OK, two claims will be automatically created:
- Usually the primary claim will have a status of **Waiting to Send**.
- The secondary claim will have a status of **Hold until Pri received**. This claim will stay in the patient's account with the **Hold** status until sent.

To manually create a secondary claim, highlight the procedures, then click the New Claim dropdown and select **Secondary**. This is needed if the secondary plan was added after creating the primary claim.

Primary and Secondary claims look like this in the patient account:
After you receive the primary claim and enter the payment, you will receive one of two popups:

1. If the Account Module Preference for Prompt for secondary claims is checked, you will get a prompt with three options.

   - **Change the claim status to ‘Waiting to send’**: Change the status of the secondary claim to Waiting to Send.
   - **Send secondary claim(s) now**: Send the secondary claim now.
   - **Do Nothing**: Do not change the secondary claim.

2. If the Account Module Preference for Prompt for secondary claims is unchecked, you will get a prompt with a list of secondary claims.

   - Use this information to find and open the secondary claim, verify the claim estimates, and send the secondary claim.

**Electronic Claims:**
- If sending electronically in 4010 format, the claim information sent to the clearinghouses will not include primary claim payment information.
- If sending electronically in 5010 format, the claim information sent to the clearinghouse will include primary claim payment information.

**Attachment requirements depend on your clearinghouse.** Also see Electronic Attachments(227).
- Some clearinghouses require that attachments are uploaded to the clearinghouse first.
- Some clearinghouses only require that claim attachments are marked electronic when sent. They will then notify you when the attachment is needed. See Edit Claim - Attachments Tab(214).
Set Coordination of Benefits (COB) (134) rules in Family Module Preferences (637).

Write-offs for PPOs are typically done on the primary claim only.

Procedures Marked as Do Not Bill to Insurance
Procedures marked as Do Not Bill to Ins can be changed per insurance estimate.

Double-click on the procedure to view the Claim Procedure (221). Double-click on the estimate and uncheck Do Not Bill to This Insurance. Estimates will then look like this on the procedure:

<table>
<thead>
<tr>
<th>Ins Plan</th>
<th>Pri/Sec</th>
<th>Status</th>
<th>NoBill</th>
<th>Copay</th>
<th>Deduct</th>
<th>Percent</th>
<th>Ins Est</th>
<th>Ins Pay</th>
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</thead>
<tbody>
<tr>
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<td>Est</td>
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<td></td>
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</tr>
<tr>
<td>Dental Dental (Jolene Leota)</td>
<td>Sec</td>
<td>Est</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

When creating the claim, highlight the procedures and click New Claim. You will get a prompt explaining the procedure will be excluded from the insurance marked as NoBill.

Estimates
If primary insurance is received and not paid as estimated, secondary insurance estimates do not automatically update.

If a patient has both primary and secondary insurance and you want benefit estimates to be more accurate, you must set both up as a PPO Percentage plan type. See PPO Insurance Plan (114), Option 1.

Write-off might show zero if plan has a plan type of Category Percentage, and secondary plan is PPO. To change this, see Family Module Preferences (637), Calculate secondary insurance PPO write-offs (not recommended, see manual). This should only be checked if you understand COB rules and use PPO Percentage Plan types for all in network insurance plans.

Coordination of Benefits (COB)
Coordination of benefits are the rules for how insurance pays when a patient has coverage under more than one plan. You can set up defaults in Family Module Preferences (637). There are many different ways to calculate COB, made even more complicated by various State laws. Non-duplication rules can vary, depending on the carrier.

In the Edit Insurance Plan (81) window, Other Ins tab, select a Coordination of Benefits rule for use with a Secondary Insurance (132) plan.
Open Dental has the following different COB options.

**Basic:** Secondary pays the lesser of:
1. The amount that it would have paid in the absence of any other coverage.
2. The secondary allowed amount minus what primary paid.

For example, on a $100 procedure, primary might pay $80 (80% of its allowed fee).
- If the secondary allowed amount was $110, secondary would pay the lesser of $88 or ($110 - $80), so $30.
- If the secondary allowed amount was $90, secondary would pay the lesser of $72 or ($90 - $80), so $10.
- As a second example, on a $100 procedure, primary might pay $50 (50% of its allowed fee).
- If the secondary allowed amount was $110, secondary would pay the lesser of $55 or ($110 - $50), so $55.
- If the secondary allowed amount was $90, secondary would pay the lesser of $45 or ($90 - $50), so $40.

**Standard:** Secondary pays the lesser of:
1. The amount that it would have paid in the absence of any other coverage.
2. The patient's portion under the primary plan.

For example, on a $100 procedure, primary might pay $80 (80% of its allowed fee).
- If the secondary allowed amount was $110, secondary would pay the lesser of $88 or $20, so $20.
- If the secondary allowed amount was $90, secondary would pay the lesser of $72 or $20, so $20.
- As a second example, on a $100 procedure, primary might pay $50 (50% of its allowed fee).
- If the secondary allowed amount was $110, secondary would pay the lesser of $55 or $50, so $50.
- If the secondary allowed amount was $90, secondary would pay the lesser of $45 or $50, so $45.

**Carve Out:** (Non-Duplication) Secondary reduces what they will pay by what primary paid.

**Calculation used:** \[ \text{Secondary InsEst} = (\text{Secondary Allowed} - \text{Secondary Deductible}) \times \text{Secondary Percentage} - \text{PaidOther} \]

Example with deductible: On a $1500 procedure, primary might pay $750 (50% of its allowed fee).
- If secondary allowed amount was $1200, secondary deductible was $50 and secondary percentage was 80%, then secondary would pay: $170
  \[ 170 = (1200 - 50) \times .8 - 750 \]

Example without deductible (Non-Duplication: On a $100 procedure, primary might pay $80 (80% of its allowed fee).
- For example, on a $100 procedure, primary might pay $80 (80% of its allowed fee).
- If secondary allowed amount was $110, secondary would pay $88 - $80 = $8.
- If secondary allowed amount was $90, secondary would pay $72 - $80 = $0.
• As a second example, on a $100 procedure, primary might pay $50 (50% of its allowed fee).
• If secondary allowed amount was $110, secondary would pay $55 - $50 = $5.
• If secondary allowed amount was $90, secondary would pay $45 - $50 = $0.

**Secondary Medicaid:** Secondary reduces what they pay by what primary pays. The estimated patient portion becomes a write-off for the secondary insurance.

**Note:** Only use this rule if you are allowed to use Medicaid as secondary.

**Calculation used:** \( \text{ProcFee} - \text{Pri Ins Pay Est (or Ins Pay)} - \text{Pri WO} - \text{Sec Ins Est} \)

Examples: On a $100 procedure, primary insurance might allow $70, pay $35, and write off $30. Secondary insurance might allow $20, pay $0, and write off $35. The patient will pay $0.

On a $100 procedure, primary insurance might allow $40, pay $20 and write off $60. Secondary insurance might allow $30, pay $10 and write off $10. The patient will pay $0.

**Birthday Rule:** This is a method used to determine when a plan is primary or secondary for a dependent child when covered by both parents’ benefit plan. The parent whose birthday (month and day only) falls first in a calendar year is the parent with the primary coverage for the dependent.

**Insurance History**

Insurance history allows users to record previous treatment dates for procedures completed outside the practice, so Open Dental can calculate frequency limitations accurately.

In an **Insurance Plan**(81), click **Hist**.

Alternatively, in the **Family Module**(59), at the bottom of the insurance plan, double-click the insurance history grid.
Tracking insurance history is useful when using Frequency Limitations(104). By entering the previous date for procedures completed outside the office, Open Dental can calculate frequency limitations accurately.

Dates listed are based on the most recent applicable procedure with a Completed status attached to a received claim, or an Existing Other status. If the date is from a Completed procedure and you attempt an edit, the new date will only show if it is more recent than the Completed procedure's date.

Insurance history can be updated via Electronic Eligibility and Benefits(108).

Edit which procedure codes are assigned to a category in the Treatment Plan Module Preferences(703).

To add history for a category, enter the date the procedure was completed, then click OK.

When history is added for a category, the first procedure code entered in the Treatment Plan Preferences will be entered as an Existing Other procedure in the Chart Module(298). Preferences can be edited if a different code is preferred.

When claims are received, the insurance history will update accordingly.

If insurance benefits were used outside the office, see Adjustments to Insurance Benefits(106).

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**Estimate Downgrades**

In an Insurance Plan(81), on the Other Ins Info Tab, is a button for Subst Codes.

- Use Alternate Code for some Medicaid plans
- Don't Substitute Codes (e.g. posterior composites)
- PPO substitution calculate writeoffs
- Claims show UCR fee, not billed fee
- Hidden
- Claims show base units (Does not affect billed amount)

See our QuickTip video on Customizing Downgrade Codes for an Insurance Plan.

Sometimes an Insurance Plan will reduce payment for a procedure based on material (e.g. composite to amalgam or porcelain to gold). To account for downgrades in payment for certain procedures, Open Dental can automatically calculate downgraded estimates.

In Open Dental, downgraded estimates are based on insurance substitution codes and whether or not the insurance plan is set up to apply substitution codes.

- Note: The substitution code fee is never more expensive than the original procedure code fee.
- Downgrades can include or exclude write-offs depending on your insurance setup.
- To see an example of the math behind downgrades, see PPO Insurance Calculations(116).

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**Downgrade Estimates for an Insurance Plan**

When an insurance plan is set to downgrade estimates:

- The charted code is still billed to insurance.
- The procedure's substitution code will be used to estimate the insurance fee. If no fee is entered for the substitution code, the fee for the original procedure is used instead.
- The patient will usually pay the difference between the original allowed fee and the downgraded fee.

**Set a Downgrade Universally for all Insurance Plans**

For procedures commonly downgraded by most insurances, users can create codes that default to downgrades for all insurance plans.
By default, Open Dental associates four composite procedure codes with corresponding amalgam substitution codes.

- D2391 (composite) = D2140 (substitute amalgam code)
- D2392 (composite) = D2150 (substitute amalgam code)
- D2393 (composite) = D2160 (substitute amalgam code)
- D2394 (composite) = D2161 (substitute amalgam code)

To create additional universally downgraded codes:

In the **MainMenu** (592), click Lists, **Procedure Codes** (1195).

Make sure the correct fees are entered in the fee schedule for both the procedure code to be completed and the substitution code.

Double-click the procedure code to be completed.

![Edit Procedure Code](image)

In the Ins. Subst Code field enter the insurance substitution code. In the above example, composite code D2391 has an amalgam substitution code of D2140.

Optionally set the **Only if** condition.

- Always: Always downgrade this procedure code.
- Molar: Only downgrade when procedure is performed on a molar.
- Second Molar: Only downgrade when procedure is performed on a second molar.
- Never: Never downgrade this code.
- Posterior: Only downgrade when this procedure is performed on a posterior tooth.

**Set a Downgrade on the Insurance Plan Level**

By default, insurance plans are set to apply downgrades for all procedure codes with substitution codes (Don't Substitute Codes is unchecked). Optionally, insurance plans can have specific downgrades set, or universal downgrades can be excluded.

Open the Insurance Plan, Other Ins Info Tab.

Make sure the option **Don't Substitute Codes** is unchecked. This is unchecked by default and determines whether the plan calculates downgrades. This will affect all procedures with substitution codes, unless you specify which codes to include/exclude.

Select whether or not to calculate write-offs by checking or unchecking **PPO substitution calculates writeoffs**. The write-off is calculated using the office fee and and the fee for the originally charted procedure.

To control which procedure codes are downgraded for this plan, click **Subst Codes**.
Click + to add a new substitution code.
- When prompted, select the charted procedure code from the Procedure Code list, then type in the downgraded procedure code in the SubstCode column.
- Use the SubstOnlyIf column dropdown to select the condition.
- When changes are made in this window, an X will display in the InsOnly column, indicating the change is at the insurance plan level.

**Do not Downgrade Estimates for an Insurance Plan**
To turn off downgraded estimates for a plan, on the Edit Insurance Plan window, Other Ins Info tab, check **Don't Substitute Codes**. All estimates for the plan will be based on the procedure to be completed and substitution codes will be ignored.

When an insurance plan is set to not downgrade estimates:
- The charted code is billed to insurance and used to estimate the insurance payment.
- If insurance downgrades the fee, the estimated insurance payment in Open Dental will be inaccurate (too big).

To exclude a specific procedure code from being downgraded, change the SubstOnlyIf column to **Never**.
Recall

Customize a patient's recall interval, change the prophy recall to perio, delete/disable a patient's recall type, or add custom types from the Recall grid.

In the Family Module (59), double-click the Recall grid.

A patient's recall appointments are determined by their Recall Types (635). Every patient is assigned a prophy recall but can be set to perio as needed and other custom types may be added. When a recall types' procedures are set complete, the patient's next recall appointment due date is calculated. The recall due date, along with the scheduled date, recall status, and recall notes for each of a patient's recall type show in the Recall grid.

**Edit Recall**

Double-click the grid to edit the recalls for the patient.

Recalls: Lists the patient's recall types and the types' previous due date, current due date, and scheduled date. The recall interval, status, and notes about the recall will also show. Every time a recall appointment is set complete, the dates, status, and notes reset.

**Add:** Click to add another recall type for the patient. In the Edit Recall window, select the Type from the dropdown, set a custom recall interval (optional), and click OK to save.

**Set Perio/Set Prophy:** Click to replace the prophy recall with the perio recall type. The due dates will update to reflect the perio interval. To change back to prophy, click Set Prophy.

Double-click an existing recall type to edit, disable, or delete.
Type: The currently selected recall type. Cannot be changed.

Recall Interval: Automatically populates the default interval set for this recall type. To change for this patient only, enter a new value in one of the fields. To change for all patients, edit in Recall Types (635).

Previous Date: The date of the patient's last recall appointment for this recall type. This is based on the completed procedures that trigger the recall.

Calculated Due Date: The recall due date based on the Previous Date plus the recall interval.

Actual Due Date: Typically the same as the Calculated Due Date but may be changed. When the same, syncing recall types will update this date but if different, syncing will not update this date.

Scheduled Date: The date of the scheduled recall appointment (if scheduled).

Status: The current communication status of this recall with the patient. Updating the status should typically be done through the Recall List (27) as manually setting the status from the Edit Recall window will not update the number of reminders sent. Use the dropdown to select a new status. The status is reset to None when the recall appointment is set complete. Status options may be customized in Definitions: Recall / Unsched Status (887).

Schedule ASAP: Check to indicate the patient would like to be contacted as soon as an opening becomes available. The appointment will be added to the ASAP List (43).

Administrative Note: Add notes about this patients recall. If using quick notes, right-click to insert Quick Paste Notes (1088) or use the quick note shortcut. Notes may also be added through the recall list. When the recall appointment is set complete, the note is removed.

Disable Recall
Disable a patient's recall from the Edit Recall window. The patient will be removed from the recall list.

Always Disable: Check to disable recall for this patient until the box is unchecked. The recall dates, status, and note will be saved but the due date will be removed.

Until family Account balance is below: Temporarily disables the recall type for the patient until the family balance is below the amount entered.

Until Date: Temporarily disables the recall type for the patient until the date entered.

To remove a recall type from the Recalls for Patient grid, click Delete. If a Previous Date is entered, delete will reset the Status, Administrative Note, and Disable Recall parameters. Check Always Disabled instead.
Patient Picture

In the Family Module (59), at the upper left, is the Patient Picture.

Optionally it will also display when you hover over an appointment in the Appointments Module (1).

Add a Patient Picture

By default, new patient photos are stored in the Patient Pictures folder of the Images Module (480). The most recent image in the folder is used as the patient picture. Typical file types are jpg, gif, and png.

To change the folder that stores patient pictures, see Definitions: Image Categories (869).

Take a Picture

To take the patient's picture, use a webcam or digital camera, then save the image in an appropriate file format (jpg, gif, png).

Webcams can be used in Open Dental if the proper TWAIN driver is installed. If a TWAIN driver is installed, you can take a patient picture using the scan button. Open Dental does not support a live feed so you will not be able to view the image before it's taken.

Note: It is hard for us to give recommendations regarding specific models of webcam due to the vast number of models and differences in customer hardware. Keep in mind that whichever webcam model you use, it is a requirement for it to function with a TWAIN driver. Be aware that some newer webcams no longer provide TWAIN drivers.
To add the image to Open Dental, you have two options:

1. In the Images Module, Patient Picture category, click Import.
2. Drag and Drop. In File Explorer, or on your desktop, select the image. Drag and drop the image into the Images module Patient Picture category.

**Remove a Patient Picture**

To permanently remove a picture, in the Images Module, right click the image file and select Delete.

To add or remove the patient picture from the appointment bubble:
1. In the Main Menu, click Setup, **Display Fields** (900).
2. Double click on Appointment Bubble.
3. Move Patient Picture to or from the Fields Showing list.
4. Click OK to save.

Note: It is hard for us to give recommendations regarding specific models of webcam due to the vast number of models and differences in customer hardware. Keep in mind that whichever webcam model you use, it is a requirement for it to function with a TWAIN driver.

**Super Family**

In the **Family Module** (59), super families can be used to group patients that are related in some way.

For example, a super family could consist of all patients in a particular nursing home, a split family due to divorce, or members of an athletic team getting mouthguards. You can bill families individually or create super statements that include the account activity for all super family members.

The guarantor of the first family added to a super family is considered the super head. This family is listed first in the Family module, Super Family grid in bold red.

- To quickly switch between families or patients, click on a name.
- The sort order of families is determined by the super family sorting strategy selected in Family Module Preferences.
- If a family’s guarantor is included in super family billing, an X shows in the Stmt column.
- To add the name of the super head to the Patient Information area, add **Super Head** to Fields Showing in **Display Fields** (900), Patient Information.

**Turn on Super Families**

To use this feature, turn on Super Families in **Show Features** (806) and restart Open Dental. The following options will then be available in the Open Dental interface.

- Family Module toolbar, Super Family buttons (Add, Remove, Disband).
- **Edit Patient Information** (62), Included in Super Family Billing checkbox.
Set default options in Family Module Preferences (637), Super Family tab:
- Super family sorting strategy.
- Allow syncing patient information to all super family members.
- Copy the super head's primary insurance to all new super family members.
- If using Clone (145), opt to place new patient clones in a new family and associate them with original patients via super family.

Create a Super Family / Add Super Family Members
To create a super family, first add the super head, then add other families.

1. Select the patient (guarantor) who will be the super head.
2. In the Family module toolbar, click SuperFamily: Add. The first time you click it, all family members of the super head will list in a new Super Family section (in bold red).
3. To add other families to the super family:
   1. Click Super Family: Add again.
   2. Select the patient.
   3. If you have turned on the prompt to copy the super head's insurance to new members of the new family, a message will show

   ![Message](image)

   Click Yes to copy the super head's primary insurance plan to the each patient in the new family. For each copied plan the following will occur:
   - The patient's Medicaid ID will be used as the Subscriber ID. If there is no Medicaid ID entered, you will be prompted to enter the subscriber ID on the Insurance Plan (81).
   - The default Relationship to Subscriber will be set to Self.
   - If the patient has no other insurance, the plan will added as the primary insurance (order = 1). If other plans are entered, the plan will be given then next available order number (order = 2, 3, etc).

   Click No to add the family without copying insurance plans.

Super Family Statements / Invoices
Statements and invoices can be sent to each family guarantor, or you can create super statements or invoices that are addressed to the super head, include account activity for all patients in the super family, and are grouped by the family guarantor.

Note:
To be included in a super statement or invoice, each guarantor of a family must have Included in Super Family Billing checked on the Edit Patient Information window.
4. Select other options as needed.
5. Click **Print**, **Email** or **OK** to generate.

Create a super statement using the billing list:

1. In the Manage Module (487), click **Billing**. See Billing (504).
2. Check the **Group by Super Family** box.
3. Click **Create List**. Only the super head will have a statement generated.
4. Click **Print**, **Email** or **OK** to generate.

Create a super invoice:

1. Select any patient in the super family.
2. From the Account module, click the Statement dropdown, **Invoice**. See Invoice (272).
3. Select the procedures, payment plan debits, and adjustments.
4. Select **Send to Super Family**.
5. Select other options as needed.
6. Click **Print**, **Email** or **OK** to generate.

All patients included in a super statement or invoice will have a statement entry added in their patient account ledger.

**Remove a Patient/Family**
To remove a patient/family from a super family, click on their name, then click Remove. The screen will switch to the removed guarantor's record. Any super statements generated for patients in the removed super family will no longer show in their patient account ledger.

**Disband a Super Family**
Disbanding a super family removes the relationship between all members of super family. A confirmation message will show to verify the removal. Any super statements generated for disbanded family members will no longer show in their patient account ledger.

**Clone**
Patient Clones are a useful feature for practices that have different types of providers who treat the same patient. The tool can be used to create one or more clones of the original patient, with data continually synched between patient and clone.

For example, a general dentistry office may also provide orthodontic and endodontic treatment.
- Use the original patient record to track general dentistry work.
- Create a patient clone with a specialty of orthodontics to track orthodontic work.
- Create another patient clone with a specialty of endodontics to track endodontic work.

**Turn on Patient Clones**
For patient clone options to show in the interface, **Patient Clone** must be turned on.

In the Main Menu (592), click Setup, Advanced, **Show Features** (806).

Check the box for Patient Clones and click OK.

Restart Open Dental.

**Patient Clones in the Family Module**
Manage patient clones, create new patient clones, and view patient clone relationships in the Family Module (59).
The original patient is listed in mixed case (e.g. Smith, John). Clones are listed in all capital letters (e.g. SMITH, JOHN).

**Family Members grid:** By default, patient clones are added to the original patient's family (Family Members grid).

Another option is to place new patient clones in their own family, and associate the clone to the original via Super Family (143). This is useful when you want to maintain separate financial accounts for each clone (e.g. send separate statements for orthodontic versus dentistry work).

1. Turn on Super Families and restart Open Dental.
2. In Family Module Preferences (637), Super Family tab, check the preference for *New patient clones use super family instead of regular family*.
3. Create the clone. A separate Super Family grid will show in the Family module with the original patient as the super head and clones as family members.

**Patient Clones grid:** This grid shows when one or more patient clones exist. The original patient will list in red with clones listed below.

**Specialty:** Assigning specialties is optional, but can be a useful method of differentiating patient clones.
- Set up specialty options in Definitions: Clinic Specialties (862)
- Assign specialties when creating the clone or on the Edit Patient Information (62)
- Include specialty in the Title Bar and Patient Select Area of the Account Module. See Miscellaneous Setup (921).
- Include specialty in the Select Patient window and Chart Patient Information. See Display Fields (900).

Note: To exclude patient clones from the insurance verification list, see Insurance Verification Setup (627).

**Add Patient Clones**

In the Family module, select the original patient.

In the toolbar, click Add next to Clones.

In the Clone Add window, select the clone's primary provider, specialty and clinic.
Primary Provider: Defaults to the provider selected on the patient’s Edit Patient Information window. Click the dropdown or [...] to change.

Specialty: The clone’s specialty. Unspecified can only be selected when the selected clinic has no associated specialty. Only specialties not already associated to the patient are options.

Clinic: The clone’s clinic. Only clinics associated with the selected specialty are options (See Clinic List(1223)).

Click Clone to create the clone. It will list in all caps.

Break Patient-Clone Relationships
To break the relationship between a single patient clone and the original patient:
1. In the Family module, select the patient clone.
2. Click Break.
3. A confirmation message will show. Click Yes to break the relationship.

To break all relationships between the original patient and every patient clone:
1. In the Family module, select the original patient.
2. Click Break.
3. A confirmation message will show. Click Yes to break the relationship.

Once the relationship is broken, clones no longer list in the Patient Clones grid, but will still list as family members or super family members.

Link Duplicate Patients as Clones
If a duplicate account exists for a patient, you can use the patient merge tool to turn the duplicate account into a patient clone.
1. On the original account (the account you want to keep), create a patient clone (see above).
2. Open the Merge Patients(1407) tool.
3. Merge the duplicate account into the newly created patient clone.

Synch Original Patient and Clone
The following information can be synched between the original patient and clones.

- First Name
- Last Name
- Preferred Name
- Middle Initial
- Responsible Party
Insurance coverage amounts are not synched (amounts used and benefits available), so insurance estimates may be inaccurate. If you want both original and clone to reflect updated amounts, whenever an amount changes for one, add Adjustments to Insurance Benefits (106) for the other.

Note: This may not be an issue if general dental and orthodontic benefits are different and you have entered Ortho Lifetime Max and Percentage as Benefit Information (86).

Synch Information:
In the Family module, Family Members grid, select the patient or clone.
Note: If you synch from the clone, all clone names will become ALL CAPS, and the original patient name will become mixed case (e.g. John L. Smith).

In the toolbar, click Synch.

Click Yes to continue.

A detailed list of synched changes will list.
Click OK to close the window. Click Print to print a copy of all changes.

**Troubleshooting**
Version 17.1 and earlier: If the original patient's first and last name is in ALL CAPS, you may be blocked from creating a clone. To resolve, change the original patient name so first and/or last name is not in all capital letters (Smith, John). Then you will be allowed to create the clone.

Bridges to other software: Open Dental always sends the information of the original patient to bridged software, not the clone. If, in the bridged software, information is associated with the clone, you may have issues accessing it. We recommend moving all information to the original patient instead.

**Discount Plan**
For patients without insurance, a Discount Plan can be added to offer office defined discounts.

In the Family Module toolbar, click Discount Plan.

Select from the Discount Plans list to add to the patient. It will list under a Discount Plan area (replaces the Insurance Plan area). Discount Plans cannot be attached to patients who have insurance.

Double-click in the Discount Plan area to change the plan's description, adjustment type, or fee schedule.

**View Discount Amounts in the Treatment Plan Module**
In the Treatment Plan module, fee estimates will consider the discount plan. To show the discount amount in the Procedures grid:
1. Add DPlan to TreatmentPlanModule in Display Fields.
2. In the Treatment Plan, double click the unsaved Treatment Plan (active or inactive), and set the Plan Type to Discount.
Drop a Discount Plan
There are two ways to drop a discount plan from a patient:

1. In the Family Module, select the patient, double click the discount plan area, then click Drop on the Discount Plan Edit window.
2. In the Family Module, select the patient, then click the Discount Plan dropdown, Drop Discount Plan.

Account Module
The Account Module(1) is where a patient's financial and claim history is viewed.
By default the selected patient's information is displayed.

Webinars: Account Module Webinars.

Set default options in Account Module Preferences(693).

**Account Toolbar**

**Payment:** Click the button to enter Payment Allocation(158). Click the dropdown to allocate unearned income or transfer income. See Allocate Unearned Income(193) or Income Transfer(199).

**Adjustment:** Click the button to enter single negative or positive Adjustment(203). Click the dropdown, Add Multiple to enter multiple adjustments attached to multiple procedures at once. Click the dropdown, Apply Sales Tax to apply a Sales Tax(207) adjustment to a procedure.

**New Claim:** Click the button to Create a Claim(208) based on insurance plan situation. Or click the dropdown to select another option:
- Primary: Create a primary dental claim.
- Secondary: Manually create Secondary Insurance(132).
- Medical: Create a medical or institutional claim.
- Other: For patients with three or more dental insurance plans.

**Payment Plan:** Set up Payment Plan(239) or Insurance Payment Plans(258) (e.g. orthodontics).

**Installment Plan:** Set up Installment Plan(260). This is a quick alternative to a payment plan.

**Quick Procs:** Quickly add procedures to a patient's account. See Quick Procs(261).

**Repeating Charge:** Add Repeating Charges(1465) to the patient's balance on a monthly basis. Useful for orthodontic offices.

**Statement:** Click the button to send a statement to the printer. Click the dropdown to select another option. See Statement(269).
- Walkout: Send a walkout statement directly to the printer.
- Email: Email a PDF version of the full statement.
  
  Note: To securely email statements, see Electronic Billing(514). Regular email is not a secure method of sending statements (PHI).
- Receipt: Send Receipt(271) directly to the printer.
- Invoice(272): Generate an invoice.
- Limited Statement: Generate a limited statement that only includes selected procedures and associated transactions.
- More Options: Open the Statement Window(264) to select specific statement options.

**Questionnaire:** Launch the Questionnaire(1195) feature. Only visible when turned on in Show Features(806).

**TrojanCollect:** Launch Trojan Express Collect(1074). Only visible when turned on in Show Features.

**Aging and Balance Due**

Typically, Aging(1423) (30/60/90 days past due) is updated daily for all patients. Every time you open a patient's account, the aging is also recomputed for accuracy.

Next to aging, the estimated balances after insurance pays can be seen.
- Total: The total balance for all family members.
- Ins Est: The total insurance pending amount for all family members (estimated insurance payments + estimated write-offs).
- Est Bal (bold red): The total remaining balance for the family after subtracting pending insurance amounts.
- Pat Est Bal: The selected patient's balance after subtracting pending insurance amounts.
- Ins Rem: Hover over the box see insurance remaining. The amounts are calculated the same way as in the Treatment Plan module.
- Unearned: The amount of Unearned / Prepayment(191).
• Note: If using patient payment plans, the pay plan logic determines whether or not Total, Est Bal, and Pat Est Bal include payment plan amounts due.
• If *Balances don't subtract insurance estimate* in Account Module Preferences is turned on, the captions above balance information are different (Balance (bold red), Ins Pending, After Ins, Pat Est Bal). This option is useful if your office does not accept insurance assignment of benefits and the patient pays the full amount regardless of the insurance estimate.

To give you as many choices as possible, there is not a close out process at the end of the month to put procedures into history. Instead, if you don't want previous entries to be altered, assign security permissions to users based on date. Older entries can still be changed, but only if you have permission and the correct password. Procedures themselves are always protected from alteration regardless of your security settings. See Security(1106).

**Payment Plans**
When the patient is associated with a Payment Plan(239), details show in the Payment Plan grid. Double-click a plan to view terms, amortization schedule, or to edit.

Credits, debits, and payments for patient payment plans can optionally show as line items in the patient's account ledger and affect balances and aging. See Payment Plan(239) for a description of options.

**Patient Account Tab**
The patient's account ledger. All procedures, grouped by date with related claims, insurance payments, patient payments (and pay splits), adjustments, statements, invoices, and receipts are listed. Depending on your payment plan logic, payment plan credits, debits, and payments may also show. The sort order is as follows:
• All items are sorted by date.
• Procedures are listed first, followed by adjustments, then other items.
• Procedures are sorted first by status, then by priority, tooth range, tooth number, procedure code, and lastly procedure number.

Double-click an item to edit. Click a claim or adjustment to highlight attached procedures.
• Customize text colors for entry types in Definitions: Account Colors(838).
• Customize the columns that show in Display Fields(900), Account Module.
• Running balances never take into account pending insurance estimates.
• Insurance payments use the payment date of the Claim Procedures (claimprocs)(221) attached to the claim. If a claim has procedures with different payment dates, there will be multiple line items for Insurance Payment for Claim.

Procedures marked as (In Process) are part of a group of procedures. Typically these cannot be sent out on claims until all other procedures in the group have also been completed.

**Ortho Case Tab**
This tab only shows if *Show ortho case in account module* is selected in Ortho Setup(927). View the patient's orthodontic details. See Ortho Case(275).

**Hidden Splits Tab**
The Hidden Splits(276) Tab appears when a prepayment is allocated to a treatment planned procedure.

**Communications Log (Commlog)**
The Commlog(1654) lists all commlog entries for the patient. There is a splitter between the main account grid and the log. Drag the splitter up or down to shrink or expand the log.

**Main Tab**
**Fam Urgent Fin Note:** This note applies to the entire family. It shows in red and is meant for very important financial notes. It also shows in red in a variety of other places throughout the program. If you have monitors that are visible to the patients and you don't want them to accidentally see your note, type see below on the first line. Then hit the enter key a few times before typing your note. This will force users to scroll down to see the note.

**Service Date View:** Click to open Service Date View.

**Credit Card Manage:** Manage stored patient credit cards. See Credit Card Manage(277).
**Select Patient**: Lists all family members. Click on a patient to switch patient accounts.

**Family Financial**: These notes are not tracked in the audit trail. This is an older version of the commlog.

**Show Tab**
Select which information displays in the patient's account ledger.

- **Start/End Date**: Filter line items by date. Enter a start and end date manually then click Refresh, or click a button to select today only, Last 45 Days, Last 90 Days, or All Dates (no date range).

- **Show Proc Breakdowns**: Display additional financial information in the description column for each procedure (e.g. patient portion, insurance paid, write-off, adjustment). This checkbox is user specific. To show the breakdown on statements, select *Show procedure breakdown* in Manage Module Preferences(744).

- **Show Family Comm Entries**: Show commlog entries for the entire family rather than just for the current patient.

- **Show Completed Pay Plans**: Show patient payment plans that have been closed. See Close Payment Plan(248). This setting will affect all workstations.

**Patient Information**
This grid only shows if you have added fields to Display Fields, Account Patient Information. It can list billing type and custom patient fields. See Patient Fields(687) to add or hide definitions in this list.

**Payment**
In the Account Module(150), click Payment.
Enter a patient payment or process a Patient Refund (194). By default, payments are automatically allocated to procedures, providers, and clinics. To change Patient Payment (158) settings, see Payment Preferences (159).

Creating a Payment

To enter a payment, select the charges (adjustments, pay plan debits, procedures) from the patient ledger, then click Payment.

Alternatively, just click Payment.

Enter the payment amount.

Check Prefer this patient to apply the payment to the patient's oldest outstanding charges. Or, leave unchecked to apply the payment to the oldest outstanding charges for the whole family.

Click OK to open the payment window and enter the payment details.

Note: When charges are selected, the payment amount is split between the charges by their remaining patient portion due. Any charges with no balance due, are skipped, and the payment is automatically split to the next oldest outstanding charge. If a selected charge was previously overpaid, the overpaid amount is deducted from the charge and re-allocated to another charge within the current payment.
**Payment Details**

**Clinic:** The default clinic is determined by the Account Module Preference (693), Payments Use Patient: Clinic. Click the dropdown to select a different clinic. Clinic specified will determine which payment process credentials are used for merchant service if defined per Clinic (1505).

**Paid By:** The name of the patient making the payment. When a payment is split to multiple family members, the payment description will show the paid by name.

**Entry Date:** The date the payment is entered.

**Payment Date:** The date the payment is received. It will be used on Deposit Slips (516).

**Amount:** The payment amount. This amount must match the total Current Payment Splits amount (see below).

**Prepay Button:** See Unearned / Prepayment (191).

**Check #:** Optional, but recommended. Check number is a good way to distinguish one check payment from another and find a lost check on a report.

**Bank-Branch:** Optional. Bank-Branch is a good way to differentiate check payments with the same check number and/or same payment amount.

**Note:** A note is automatically added after processing a credit card payment, with the Credit Card Transaction Details (188). Optionally, add a note that appears in the patient’s account as the payment description with the payment type. Notes will show on statements when the Manage Module Preference (744), Show notes for payments is checked.

**Payment Type**

None (Income Transfer): When checked, the Pay button changes to Transfer or Proc Breakdown and the Outstanding Charges grid groups by patient, clinic, and provider. These options are useful to transfer income. See Income Transfer (199).

**Payment Type:** The type of payment. Customize options in Definitions: Payment Types (879). Whether or not a type is selected by default is determined by the Account Module Preference, Payments prompt for Payment Type. For transactions processed through an integrated credit card program, the payment type defaults to the type selected in the Credit Card Payment (166) program link.

**Pay Into Account:** If using the Accounting (546) feature, and auto payment entries are setup for the selected payment type, use the dropdown to select an asset account to debit or credit the payment to. See Accounting Setup (551).

**Credit Card**

See Credit Card Payment (166).

**Recurring Charge**

Apply to Recurring Charge: Check to apply this payment to scheduled CC Recurring Charges (1430). If more than one recurring charge is scheduled for a month, the window below will display. Select the desired recurring charge date from the drop down list.

![Recurring Charge Month](image)

Which month should this payment be applied to?

10/21/2019 Previous Charge Dates

![OK Cancel](image)

**Payment Splits**

Hide Splits/Show Splits: Click to toggle between payment split views. The default view is determined by the Account Module Preference, Hide paysplits from payment window by default.
Current Payment Splits: Lists this payment's current Payment Splits (161) (paysplits) allocated to providers, clinics, patient, procedure, adjustments, pay plan charges, etc. It also lists unallocated paysplits (Unearned / Prepayment (191)).

- Delete Splits: Delete the selected paysplits from the grid. The total amount of the deleted split is added back to the Amt End under Outstanding Charges for future splits.
- Delete All: Delete all the paysplits in the grid. All paysplit amounts are added back to the Amt End under Outstanding Charges for future splits.
- Add Split: Manually add a paysplit.
- Total: The sum of all current payment splits. The Total must match the total payment Amount.

Outstanding Charges: Lists all adjustments, pay plan charges, and completed procedures in the family that have a balance remaining (patient portion due). The list also includes treatment planned procedures, (TP), when the Account Module Preference, Allow prepayments to allocate to treatment planned procedures is checked. The Outstanding Charges label will change to Outstanding Charges and Treatment Planned Procedures.

- Amt Orig: Amount owed on a charge prior to any payments, adjustments, or insurance estimates.
- Amt Start: Amount owed on a charge after all payments, adjustments, and insurance estimates but excluding the current payment.
- Amt End: Amount owed on a charge after all payments, adjustments, and insurance estimates including the current payment.
- Total: The total amount of all the selected outstanding charges.

To change what shows in grid, use the Filtering options.

Show Only Allocated Credits: Only show procedures if they have a remaining balance after their attached adjustments and payments have been applied. Credits not allocated to a procedure will be ignored. This may be useful if an outstanding charge is not listed because it has been indirectly paid off by unallocated credits.

Show Super Family Charges: Show or hide unpaid charges for a Super Family (143).

Show All Charges: By default, only unpaid adjustments, pay plan charges, and procedures in the family show. Check this box to also show paid charges.

Patients: Use the dropdown menu to view outstanding charges for a specific family member. Ctrl + click to highlight more than one family member.

Providers: Use the dropdown menu to view outstanding charges for a specific provider. Ctrl + click to highlight more than one provider.

Type: Use the dropdown menu to view specific charge types (e.g. adjustments, procedures, or pay plan charges).

Clinics: Use the dropdown menu to view charges for a specific clinic. Ctrl + click to highlight more than one clinic.

Amt End Min: Enter a value to limit the outstanding charges with a minimum remaining balance greater than or equal to this amount.

Amt End Max: Enter a value to limit the outstanding charges with a maximum remaining balance less than or equal to this amount.

From/To Dates: Enter a value or use the calendar dropdown to select a date range. Only procedures completed or treatment planned/scheduled in this date range will show.

Proc Codes: Narrow the outstanding charges by procedure code(s). This field is case sensitive. To enter more than one code, separate each code with a comma (e.g. D0210,D1110).

Refresh: Updates the grid when filtering options are changed.

Group By: Change the grouping of items in the grid.

- None (default): Show all charges for all patients in the family, sorted first by date (oldest charge at the top), then by procedure code.
• Provider: Combine each family member’s outstanding charges into one row per provider. When grouping by provider, the Type and Clinics filters are disabled.

```
<table>
<thead>
<tr>
<th>Prov</th>
<th>Codes</th>
<th>Amt Orig</th>
<th>Amt Start</th>
<th>Amt End</th>
</tr>
</thead>
<tbody>
<tr>
<td>DOC C</td>
<td>D0150, D0210</td>
<td>1308.34</td>
<td>241.67</td>
<td>241.67</td>
</tr>
<tr>
<td>DOC A</td>
<td>D1110</td>
<td>51.50</td>
<td>51.50</td>
<td>51.50</td>
</tr>
<tr>
<td>HYG A</td>
<td></td>
<td>14.50</td>
<td>14.50</td>
<td>14.50</td>
</tr>
</tbody>
</table>
```

• Clinic and Provider: Combine each family member’s outstanding charges into one row per provider and clinic. When grouping by clinic, the Type filter is disabled.

```
<table>
<thead>
<tr>
<th>Prov</th>
<th>Clinic</th>
<th>Codes</th>
<th>Amt Orig</th>
<th>Amt Start</th>
<th>Amt End</th>
</tr>
</thead>
<tbody>
<tr>
<td>DOC C</td>
<td>Clinic C</td>
<td>D0150, D0210</td>
<td>1308.34</td>
<td>241.67</td>
<td>241.67</td>
</tr>
<tr>
<td>DOC A</td>
<td>Clinic A</td>
<td>D1110</td>
<td>51.50</td>
<td>51.50</td>
<td>51.50</td>
</tr>
<tr>
<td>HYG A</td>
<td>Clinic A</td>
<td>D1110</td>
<td>14.50</td>
<td>14.50</td>
<td>14.50</td>
</tr>
</tbody>
</table>
```

**Pay**: Create paysplits for the selected outstanding charges.
**Transfer**: When None is the payment type, the Pay button changes to Transfer. Useful for Income Transfers.
**Proc Breakdown**: When None is the payment type and the Account Module preference, Enforce Valid Paysplits is set to *Enforce Fully*, the Pay button changes to Proc Breakdown. Useful to manually transfer income with the Pay Split Manager (202).
**Add Partial**: Create a paysplit for only part of an outstanding charge.

**Allocated tab**: Only shows if the payment has an unallocated split that has since been allocated to a provider/procedure. Click to view the paysplit allocations. Informational only.

```
<table>
<thead>
<tr>
<th>Date</th>
<th>Clinic</th>
<th>Patient</th>
<th>Amount</th>
<th>Unearned</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/26/2018</td>
<td>Hospital</td>
<td>Gerry Grayson</td>
<td>-15.00</td>
<td>Prepayment</td>
</tr>
<tr>
<td>10/26/2018</td>
<td>Hospital</td>
<td>Gerry Grayson</td>
<td>-15.00</td>
<td>Prepayment</td>
</tr>
<tr>
<td>10/26/2018</td>
<td>Hospital</td>
<td>Gerry Grayson</td>
<td>-7.99</td>
<td>Prepayment</td>
</tr>
<tr>
<td>10/26/2018</td>
<td>Hospital</td>
<td>Gerry Grayson</td>
<td>-69.99</td>
<td>Prepayment</td>
</tr>
</tbody>
</table>
```

**Buttons at Bottom**

**Print Receipt**: Reprint XCharge or PayConnect receipts. This button only shows if a receipt already exists for the transaction.

**Email Receipt**: Generate a PDF copy of the XCharge or PayConnect receipt and email it to the patient. A copy of the receipt is saved in the patient's Images Module (480).

**Delete**: Delete the entire payment. Only enabled on existing payments.
**OK**: Post the payment to the patient account. Payments allocated to procedures for multiple family members will post to each patient account.
**Cancel**: The behavior of the cancel button varies depending on the point you are at in the payment process.
• New payment no credit card transaction: If this is a new payment and no credit card has been processed, cancel deletes the payment.
• New payment with a credit card transaction: If this is a new payment and you just processed a credit card, cancel voids the credit card transaction, posts the payment, and posts and a separate voided payment.
• Editing an existing payment: Cancels any changes made in the payment window.
**Payment Allocation**

In the Payment(153) window, at the lower left, the paysplits are listed.

<table>
<thead>
<tr>
<th>Date</th>
<th>Prov</th>
<th>Clinic</th>
<th>Patient</th>
<th>Code</th>
<th>Type</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>11/10/2018</td>
<td>DOC B</td>
<td>Clinic B</td>
<td>Grayson, Gerry</td>
<td>D0150</td>
<td>Proc: CmpEx</td>
<td>121.00</td>
</tr>
<tr>
<td>11/10/2018</td>
<td>DOC B</td>
<td>Clinic B</td>
<td>Grayson, Gerry</td>
<td>D1110</td>
<td>Proc: Pro</td>
<td>152.00</td>
</tr>
<tr>
<td>11/10/2018</td>
<td>Clinic B</td>
<td>Grayson, Gerry</td>
<td>Unallocated</td>
<td></td>
<td></td>
<td>50.00</td>
</tr>
</tbody>
</table>

**Payment Splits** (paysplits) allow income to be allocated to adjustments, pay plan charges, procedures and providers, or mark a payment as unallocated (e.g. for prepayments, other unearned types).

Related Links:

Blog post: [Patient Payments: Allocating Made Easy](#)

Webinar: [Entering Patient Payments](#)

**Paysplit Allocation Options**

There are varying levels of allocation options and each are determined by a combination of the selected Account Module Preferences (693). Below is a description of each option and which preferences to select. Also, see Payment Preferences (159) for another version of this discussion.

**Allocate Paysplits by Procedure** (recommended): The suggested paysplits will be allocated to procedures and the procedure’s treating provider. Or as Unearned / Prepayment (191) (e.g. prepayments, overpayments) to be allocated later (e.g. when treatment is complete or as a refund). We recommend this method of allocation so that reports and patient accounts are as robust and accurate as possible.

- Track production and income by procedure and provider.
- Use reports to determine pay for providers based on production and/or income. See Production and Income Reports (1281).
- Easily determine patient portion by procedure on patient accounts.
- Use the Patient Portion Uncollected Report (1306) to determine outstanding patient portion amounts due by procedure.
- Create custom reports based on procedure income, provider income and patient portion remaining.
- Easily associate accurate procedures and credits to payment plan charges (Payment Plan (239)).
- Track prepayments, overpayments, or other unearned types.
- Create custom reports based on unearned income types.

Additionally set whether staff is required to allocate to procedures, or have more flexibility. Here are some questions to ask, and the settings and steps we recommend based on the answers.
This table has been omitted.

*Enforce Fully will require staff to always allocate to adjustments or procedures.

**Auto-Split only will suggest paysplits, but staff is not required to always allocate to adjustments or procedures.

If you have not been allocating payments to procedures and would like to start follow the steps below.
1. Select a date to start allocating (Allocation Date). All procedures completed on and after this date will be allocated. Procedures completed before this date should be ignored.
2. Set payment preferences.
3. Begin entering payments. Ignore all outstanding procedure charges dated prior to your Allocation Date.
4. Manually re-allocate paysplits as needed until the patient's family balance is 0.
5. Once the patient's family balance is 0, the paysplits suggested by Open Dental should accurately be allocated to the correct outstanding charges.

Note: Reports prior to your allocation date may be inaccurate.

Allocate to Providers Only (old behavior): The suggested paysplits will be allocated to the oldest procedure's treating provider with a patient portion due. Staff can manually create splits to allocate to procedures or unearned types (unallocated), but no suggestions beyond treating provider will be given. This method is only useful for small, single provider practices that do not track production or income.
- Track income by provider only.
- Some reports may not be accurate since income by procedure won't be included.
- If you decide to track/allocate later, using this method will cause problems.

Settings:
- Enforce Valid Paysplits: Don't Force
- Enforce Valid Adjustments: Don’t Enforce
- Auto-split payments preferring: Adjustments

Note: Even if you don't want to allocate to procedures, having Open Dental do the work of allocating to procedures (Auto-Split Only) will set you up for success if you ever want to allocate in the future. We suggest hiding paysplits and outstanding charges on the Payment window (see Account Module Preferences), then letting Open Dental allocate behind the scenes. As your business grows and you decide you do want to pay providers by income, or want to have more details in your production and income reports, you can quickly transition to procedure allocation.

When you have accounts where you have not directly (explicitly) allocated outstanding charges to payments in the past, Open Dental still implicitly associates outstanding charges and payments based on patient, provider, and clinic.

Payment Preferences

How Open Dental behaves when entering Patient Payments (158) is based on your selected preferences and setup options.

When deciding how to set up the system, here are a few questions to think about:
- At what level do you want to allocate paysplits? To all charges (adjustments and procedures), and providers, or providers only?
- If to procedures, do you want to force users to allocate to charges or give them flexibility?
- What payment options and unearned types should be available?

Once you have an idea of how you want the software to behave, select the preferences and options in Open Dental. If you don't know where to start, see the bottom of this page for typical scenarios and examples for the following:
1. We want to allocate to adjustments and procedures
2. We want to allocate to providers only, not to adjustments and procedures (old behavior)
3. Typical Enforce Fully Setup
4. Typical Auto-Split Only Setup
Blog post: [Patient Payments: Allocation Made Easy](#).

Webinar: [Entering Patient Payments](#)

**Setup Options**

By default, Open Dental will automatically suggest paysplits allocated first to adjustments, then to procedures. This means they are allocated to the oldest adjustment (and its treating provider), then the treating provider of the oldest completed procedure with a balance remaining (patient portion due). Below are the default settings that determine the allocation behavior.

**Definitions**(835): These definitions determine the options available as payment types and unearned types.
- Payment Types (e.g. credit card, check, EFT, refund, care credit). [Definitions: Payment Types](#)
- Paysplit Unearned Types (e.g. prepayments or overpayments). [Definitions: PaySplit Unearned Types](#)

**Account Module Preferences**(693): These preferences determine the level of allocation and logic used for allocations, as well as several default settings.

Pay/Adj tab
- Automatically store credit card tokens
- Patient Payments Use [] (determines the default clinic to assign to payments)
- Payments prompt for Payment Type
- Default unearned type for unallocated paysplits (defaults to prepayment)
- Sales Tax Percentage
- Enforce Valid Paysplits: Determines whether or not users are forced to allocate payments to adjustments, procedures and unearned types. Defaults to Auto-Split Only.
- Allow prepayments to providers
- Enforce Valid Adjustments: Determines whether or not users are forced to attach adjustments to procedures.
- Auto-split payments preferring: Determines the logic used for automatic paysplit suggestions. Defaults to Adjustments first, then FIFO.
- Hide paysplits from payment window by default: Determines whether or not users will see current paysplits and outstanding charges on the Payment window.

Insurance tab
- Payment exceeds procedure balance: Determines whether or not users are warned or blocked from allocating an insurance payment that is greater than the procedure's remaining balance (procedure fee - payments - writeoffs + adjustments). This preference is just for insurance payments. Users are always warned when over allocating a patient payment to a procedure or when an adjustment is applied and exceeds the procedure's remaining balance.

Misc Account tab
- Recurring charges use primary provider
- Recurring charges use transaction date
- Payment type for recurring charges

**Scenario 1: We want to allocate to adjustments and procedures**

In this scenario, Open Dental will suggest paysplits allocated to adjustments, procedures or as unallocated income to be allocated later. You can additionally set whether staff is required to allocate to these charges, or have more flexibility. Here are some questions to ask, and the settings and steps we recommend based on your answers.

This table has been ommitted.

*Enforce Fully will require staff to always allocate payments to adjustments and procedures, and require adjustments to be attached to procedures.

**Auto-Split Only / Link Only will suggest paysplits, but staff is not required to allocate payments to adjustments and procedures, or be required to attach adjustments to procedures.*
This table has been omitted.

**Scenario 2: We want to allocate to providers only, not to adjustments and procedures (old behavior)**

You have the option of setting Open Dental to work as it did in version 17.2 and earlier. We only recommend this method if you have no intention of ever paying providers by income, are not concerned about the detail in your production and income reports, or you want to manually create every paysplit.

Open Dental will only suggest paysplits allocated to the procedure's treating provider. Staff can manually create splits to allocate to procedures or unearned types (unallocated), but no suggestions will be given. Only useful for small, single provider practices that do not track production or income. If you decide to track/allocate later, using this method will cause problems.

Beware: When you do not allocate payments to procedures, some reports/user queries may be useless and inaccurate.

**Settings:**
- Enforce Valid Paysplits: Don't Force
- Enforce Valid Adjustments: Don't Enforce
- Default unearned type for unallocated paysplits: Prepayments

---

**Note:** Even if you don't want to allocate to procedures, having Open Dental do the work of allocating to procedures (Auto-Split Only) will set you up for success if you ever want to allocate in the future. We suggest hiding paysplits and outstanding charges on the Payment window (see Account Module Preferences), then letting Open Dental allocate behind the scenes. Then, as your business grows, you decide you do want to pay providers by income, or want to have more details in your production and income reports, you can quickly transition to procedure allocation.

---

**Scenario 3: Typical Enforce Fully Setup**

The system will suggest paysplits allocated to adjustments and procedures (outstanding charges) or to the default unearned type (unallocated). Staff can modify allocations, but all splits must be allocated to a procedure or unearned type. This method is often used by large or multi-clinic offices who require users to allocate all income, including adjustments, to procedures. This table has been ommitted.

**Scenario 4: Typical Auto Split Only Setup**

Open Dental will still suggest paysplits allocated to procedures (outstanding charges) or to the default unearned type (unallocated), but staff can also make splits not allocated to procedures (e.g. splits for adjustments). This table has been ommitted.

---

**Paysplit**

Payment Splits (paysplits) allow income to be allocated to production, providers, and clinics.

In the Payment window, click Add, or double-click an existing paysplit to edit.
Entry Date: The date the paysplit is created.

Payment Date: The payment date as entered on the Payment window.

Amount: The paysplit amount.

Unearned Type: Used to designate this split as as Unearned / Prepayment (191) (e.g. prepayments). Defaults to the type set in Account Module Preferences (693), Default unearned type for unallocated paysplits. Customize types in Definitions: PaySplit Unearned Types (880).

Clinic: The clinic to assign this income to. Defaults to the clinic assigned to the payment. Set the default clinic in Account Module Preferences, Patient payments use.

Provider: The provider to assign this income to. Click the dropdown to change the provider and select by abbreviation or [...] to select by name. If none the paysplit will be marked as a prepayment. When providers are restricted to clinics, only providers available for the selected clinic are options.

Note: If a procedure or adjustment is attached to the paysplit, the Clinic and Provider are inherited from the procedure or adjustment and will override the Account Module Preference, Patient payments use.

Patient: The patient this paysplit applies to. All family members are listed. To select a patient that is not in the family, check the Is from another family box, then select the patient.

Edit Anyway: This button only shows when opening an existing paysplit that is attached to a procedure. Click to enable the Clinic, Provider, and Patient fields so they can be edited. The Setup security permission is required.
Procedure
Attach or detach a procedure from a paysplit.

Click **Attach** to view a list of completed or treatment planned (TP) procedures with a remaining balance due. Treatment planned procedures only show when the Account Module Preference, *Allow prepayments to allocate to treatment planned procedures* is checked.

Credit Filter options:
- **Only allocated credits**: Only show procedures if they have a remaining balance after their attached adjustments and payments have been applied. Credits not allocated to a procedure will be ignored. This may be useful if an outstanding charge is not listed because it has been indirectly paid off by unallocated credits.
- **Include all credits**: Show procedures with a remaining balance after all credits, attached and unattached, have been applied. Credits not attached to a procedure are summed and indirectly applied to a procedure's remaining balance using first-in/first-out (FIFO) logic.
- **Exclude all credits**: Show all procedures on this patient's account.

Highlight the procedure to attach to the payment, then click OK. The procedure's payment information (e.g. write-off, insurance paid, estimate, adjustments) will show for informational purposes so you can enter the correct paysplit amount to bring the procedure balance to zero.

Click **Detach** to clear a procedure.

Adjustment
Attach or detach an adjustment from a paysplit.
A summary of the currently attached adjustment is displayed.

- **Date**: Adjustment date.
- **Provider**: Provider assigned to the adjustment.
- **Adjust Amount**: Adjustment fee.
- **Paid Previously**: Total payments split to this adjustment (not including the current payment split).
- **This Payment Split**: Amount paid on this paysplit.
- **Remaining**: Remaining adjustment balance after all paysplits have been applied (including the current payment split).

Click **Attach** to select from a list of positive and negative adjustments that are not linked to a procedure. The Attach option is only available if there is no procedure or adjustment currently attached to the payment split. A procedure or adjustment may be attached but not both. To attach both, instead link the adjustment directly to the procedure (see Adjustment(203)) then create a payment split and attach it to the procedure.

Highlight an adjustment to view a summary on the right.

- **Amt Original**: Adjustment fee.
- **Already Used**: Total payments split to the adjustment (not including the current payment split).
- **Amt Available**: Adjustment balance after previous payments have been applied.
- **Current Split**: Amount paid on this paysplit.
- **Amt End**: Remaining adjustment balance after all paysplits have been applied (including the current payment split).

**Payment Splits**

Use this area when there is previous Unearned / Prepayment(191) that this split should be applied to. Click **Attach**. A list of unallocated paysplits will show.
Double-click to select. Check *Show All* to include paysplits that have already been allocated to procedures.

**Attached to Payment Plan**

(checkbox at bottom of main Payment Split window). Check this box to attach this as a Payment to a Payment Plan(246).

**OK**: Save changes made to this window. If the paysplit amount exceeds the procedure's remaining balance, clicking OK will prompt the user with an *Overpaid Procedure Warning*.

**Cancel**: Close the window without saving any changes.

**Paysplit Revise**

In the Payment(153) window, double-click an existing Paysplit(161) to edit.

Paysplits that have already been allocated to an adjustment, payment plan, procedure, or unearned income may be edited or reallocated. If the payment is attached to an Accounting(546) entry, the original paysplits may only be edited within the first 48 hours of the payment date. However, we recommend only editing existing paysplits on the same day the payment is created to avoid changing historical records.

To edit a paysplit older than 24 hours, transfer the income instead of making changes to the original split. See Income Transfer(199).

**Allocate a Paysplit to another Procedure \ Adjustment**

Open the original payment. From the Payment window, double-click a payment split to edit. The Edit Payment Split(161) window will open to the either the Procedure or Adjustment tab, depending on which is attached to the split.

Click **Detach** to remove the current item.
Select the family member to re-allocate the paysplit to (upper right). Check *Is from another family* to select a patient outside the current family list.

Click **Attach** to select a new procedure or adjustment. Select the item and click OK. The clinic and provider will automatically update to what is assigned to the procedure or adjustment.

Edit the paysplit Amount (optional). If editing the amount, the difference needs to added or subtracted from another paysplit so the total payment amount matches the sum of the payment splits.

Click **OK** to save the paysplit.

Repeat steps for each paysplit that needs changed then click **OK** on the Payment window to save changes.

**Allocate a Paysplit to a Payment Plan**

Open the original payment. From the Payment window, double-click a payment split. The Edit Payment Split window will open to the either the Procedure or Adjustment tab, depending on which is attached to the split. If the paysplit is already attached to an item, click **Detach**.

Verify the **Clinic** and **Provider**.

Check the **Attached to Payment Plan** box. If more than one payment plan exists for the family, the Select Payment Plan window will open.

Select the payment plan.

Click **OK** to complete the payment split.

**Credit Card Payment**

In the **Payment** window, at the upper right, is the Credit Card area.
Open Dental has integrated with three credit card processing companies. Each service must be enabled and set up before credit card payments can be processed.

- **XCharge (OpenEdge)** (173): Supports EMV transactions (credit cards with computer chips) and processing of check payments. Supports online patient payments through the Patient Portal. Includes the Decline Minimizer, a feature that automatically updates expired and outdated card information.
- **PayConnect Window** (168): Supports EMV transactions.
- **PaySimple** (186): Supports ACH payments, direct debit payments from a patient's checking or savings account.

More than one credit card processing program may be enabled in Open Dental and clinics may set up different credentials when using different merchant accounts.

If you are a payment processing company interested in direct integration with Open Dental, please see [Direct Credit Card Integration with Open Dental](#).

### Credit Card / ACH Payments

To process a credit/debit card payment, enter the payment details in the Payment window then select a card from the Credit Card dropdown. To directly withdraw from a patient's checking or savings account (ACH payment), select the PaySimple ACH account instead. Or select New Card to enter new account information.

Click X-Charge, PayConnect, or PaySimple to initiate the credit card processor. If multiple card processing programs are enabled, and a card or account is selected, use the program listed next to the number to process the payment. Otherwise, you will be prompted to enter new card or account information.

- **XCharge (OpenEdge)** (173): Select Purchase as the transaction type. For new cards, check Save Token to safely store the card on file and click OK to enter the new card information. Click Process or F12 to charge the card.
  
  **Note:** If a card terminal is attached, swipe the card after selecting F12 Process.

- **PayConnect Window** (168): Select Sale as the transaction type. For new cards, enter the card information and check Save Token to safely store the card on file then click OK to charge the card.

- **PaySimple** (186): Select Sale as the transaction type for credit/debit or click the ACH tab for a direct withdrawal. For new accounts, enter the card or bank account information and uncheck One-Time Payment to safely store the card or bank account on file then click OK to charge the card or account.

  **Note:**

  After an ACH payment has been processed, the payment status will be marked as Posted (pending) in the Payment Note. Once the transaction is settled with the bank, the payment amount and status will need to be manually updated if declined. For users with an active registration key (are on support) and eConnector (1520), when the transaction is settled, the status in the payment note will automatically update to Settled if approved or Failed if declined. The note will also be appended with the declined payment response from PaySimple.

**Apply to Recurring Charge:** For patients with Authorized Recurring Charges (281), check to apply this payment to their next Recurring Charge (1430).

After the card or account has been processed, the Credit Card Transaction Details (188) will be automatically added to the payment note. It will indicate successful or declined transactions.

Click Print Receipt or E-mail Receipt on the payment window to manually send a receipt generated from the credit card processor. These receipts can also be set to automatically print after a successful transaction, see XCharge Setup (178) or PayConnect Setup (171). To print a receipt that shows patient account information, see Receipt (271).

Click OK to post the payment to the patient account.

- **Note:**
  - When a credit card transaction is declined, click cancel or try again. Clicking OK will post the transaction amount to the account.
  - When an ACH transaction is declined, the payment amount does not get updated automatically and will need to be manually changed. Run the Daily Payments Report (1294) and filter by the ACH payment type then reconcile the transactions with PaySimple reports to find the accounts with declined payments.
  - Clicking Cancel after a successful transaction will automatically void the payment.

### Safely Storing Credit Card Information
XCharge, PayConnect, and PaySimple use tokens to safely encrypt and store credit/debit card numbers and expiration dates or checking and savings account information with PaySimple. Storing tokens is optional. When a token is saved, the card or bank account will be listed as a masked number on the Credit Card Manage window.

Storing Tokens:
- The card number and expiration date are stored so they do not need to be re-entered each time the card is used.
- An entry for the card will be added to the credit card manage list in the patient's Account Module.
- Tokens are stored to the credit card processing program that was used to add the card or bank information. The same program will be required to process future transactions for that token. For example, a credit card was added using XCharge. The token created is unique to XCharge, and any transactions for the credit card need to be processed using XCharge.
- Tokens must be stored to use CC Recurring Charges.

If you require the card to be present for all transactions, you may prefer to not store tokens. To set the default storage option, see Account Module Preferences, Automatically store credit card tokens. You can also choose to save/not save a token when processing a single transaction (Save Token/One-Time Payment checkbox).

**PCI Compliance**
Your credit card processor may offer to enroll you in Payment Card Industry (PCI) compliance tools/assistance or charge you non-compliance fees if you do not complete the annual PCI DSS Self-Assessment Questionnaire (SAQ). PCI Compliance is required by the credit card industry for all merchants. Compliance is very difficult and time consuming to achieve. Many merchants may determine that the cost of the non-compliance fees are less than the cost of compliance. For more information: [https://www.pcisecuritystandards.org/merchants/](https://www.pcisecuritystandards.org/merchants/).

**PayConnect Window**
In the Credit Card Payment window, click PayConnect. Alternatively, in the Edit Insurance Payment window, click PayConnect.
PayConnect is an integrated Credit Card Payment(166) program that can be used to process credit and debit card transactions.


**Transaction Type:**
- Sale: A standard credit card charge. Credit Card Payment(166)
- Void: Reverse a sale soon after (same day) it was made. PayConnect Void(169)
- Return: Reverse a sale one or more days after it was made. Credit Card Return(190)

**Card Number:** Place the cursor in the field then swipe the credit card, or type the credit card number.

**Security Code:** Enter the security code from the back of the credit card. When the card is swiped the security code will auto-populate.

**Expiration (MMYY):** Enter the credit card expiration date. When the card is swiped the expiration date will auto-populate.

**Zip Code:** Enter the zipcode of the cardholder's billing address. When the card is swiped the zip code will auto-populate. When using a card on file, the zip code stored in Credit Card Manage(277) auto-populates this field.

**Name On Card:** Auto-populates with the selected patient's name, or, when the card is swiped, the cardholder's name.

**Amount:** The purchase amount entered in the payment window. To edit, cancel the transaction and enter the correct amount in the payment window.

**Save Token:** Securely store the credit card number and expiration date as a token for future use. Set the default in Account Module Preferences(693), Automatically store credit card tokens.

**Force Duplicate:** Determines if a transaction on the same card, for the same amount, on the same day may be approved. Check to allow a duplicate transaction, uncheck to decline duplicates. Set the default in PayConnect Setup(171).

**Signature Box:** Patient may sign the transaction (optional) and the signature will be stored with PayConnect. See Electronic Signatures(306) for signature capture options.

**EMV Transactions**
Credit cards with computer chips (EMV transactions) are supported for PayConnect but credit card tokens will not be saved for these transactions. Use a compatible credit card terminal and install the terminal drivers (see PayConnect Setup(171) to install drivers). Terminal options include:
- Verifone VX520
- Verifone VX805

**PayConnect Void**
In the Payment Window(166), click PayConnect(168).
PayConnect credit card payments or returns can be voided within 30 minutes of the original transaction. Voiding removes the original transaction from the patient's bank account the same day. If the transaction is older than 30 minutes or has been deposited, you can return the payment instead; returns require a few days to process. See Credit Card Return. See Credit Card Return.

**To void a PayConnect transaction**

Locate the transaction you would like to void and in the payment note identify the Ref Number and payment amount.

In the patient's Account Module, click Payment.

Enter the amount of the transaction to void/return as a negative amount (it must match the original transaction amount), then click OK to open the Payment.

Clinics: Verify the correct clinic is selected.

Current Payment Splits: Allocate voids pay split to a procedure or unearned income type.
- If voiding a payment that has been allocated: Add a pay split associated to the original procedure. Check Show All Charges, locate the charge for the original procedure, then click Add Partial and enter a negative split amount.
- If voiding a prepayment that hasn't been allocated yet, add a pay split and assign the unearned type of the original prepayment.
- If the original payment was not allocated to a procedure or unearned type, you do not need to create a pay split.

If no pay split is added an unallocated pay split will be created.

Enter the transaction information, using the same information as the original transaction (PayConnect needs this for verification purposes).
- Select Void as the Transaction Type.
- Ref Number
- Card Number, Expiration Date, and Security Code.

Click OK to process, the payment window will immediately close.
The Credit Card Transaction Details will be automatically added to the payment Note, a receipt will automatically print and the payment window will immediately close.

PayConnect Setup

In Program Links, double-click Payconnect from dentalxchange.com.

Alternatively:

- On the Payment window, right click on PayConnect, Settings.
- (During first credit card transaction) On the payment window, click PayConnect.

To set up different credentials for Clinics using different merchant accounts, see PayConnect Setup for Clinics.

Check the Enabled box.

Select the default Payment Type for PayConnect transactions. Customize options in Definitions: Payment Types. To select a different type for CC Recurring Charges transactions, see Account Module Preferences, Payment type for recurring charges.

Select the Default Processing Method: Web Service or Terminal.

Enter the Username and Password supplied by PayConnect.

To use a credit card terminal for EMV transactions, check Enable terminal processing. The Download Driver button will display. Click to download and install the terminal driver. An internet connection is required. Once the driver is installed, contact PayConnect for additional setup instructions.

Recurring charge list force duplicates by default: By default, duplicate charges to the same card, on the same day, for the same amount will be denied. This is to prevent accidentally charging a card twice. Check to allow duplicate charges on the same card by default. Used if family members have recurring charges setup on the same credit card.
Prevent saving new cards: Uncheck to allow users to process new transactions or save new payment information to a patient's account. Check to prevent users from processing new transactions or saving new payment information.

Click OK.

To set whether or not new credit and debit cards are saved to a patient's account after each transaction, see Account Module Preferences, Automatically store credit card tokens.

PayConnect Setup for Clinics
In Program Links(934), double-click Payconnect from dentalxchange.com(168).

Alternatively:
- On the Payment(153) window, right click on PayConnect, Settings.
- (During first credit card transaction) On the payment window, click PayConnect.

Clinics(1505) can use different PayConnect login credentials for each clinic in a single database.

Check Enabled (affects all clinics) to enable PayConnect for all clinics. Unchecking disables PayConnect for all clinics. If the currently logged on user is restricted by clinic, only the clinic they have access to will show in the Clinic dropdown and they will not be allowed to uncheck the Enabled box.

Clinic Payment Settings: Set the payment settings for the Headquarters first.
- Select Headquarters as the clinic.
- Select the default payment type for PayConnect transactions. Customize options in Definitions: Payment Types(879).
- Select the default processing method: Web Service or Terminal.
- Enter the username and password supplied by PayConnect.
- Enable terminal processing: Check to use a credit card terminal for EMV transactions. The Download Driver button will display. Click to download and install the terminal driver (VeriFoneUSBUARTDriver_Vx_1.0.0.52_B5.zip). An internet connection is required. Once the driver is installed, contact PayConnect for additional setup instructions.
- **Recurring charge list force duplicates by default**: By default, duplicate charges to the same card, on the same day, for the same amount will be denied. This is to prevent accidentally charging a card twice. Check to allow duplicate charges on the same card by default. Used if family members have [CC Recurring Charges](1430) setup on the same credit card.

- **Prevent saving new cards**: Uncheck to allow users to process new transactions or save new payment information to a patient's account. Check to prevent users from processing new transactions or saving new payment information.

Enter payment settings for each clinic. Headquarter settings will be used if clinic-specific changes are not made. For clinics not using PayConnect, select the clinic, then clear out the username and password. When the clinic is attached to a payment, the PayConnect button will not be visible.

Note: If the Headquarters username and password is the same as one or more other clinics, and the username and/or password is modified for Headquarters, the edits will affect the other clinics as well. To unlink them (assign different usernames/passwords), simply change the username or password for the clinic(s). Subsequent changes made to Headquarters credentials will no longer affect the clinic.

Click OK to save settings.

To set whether or not new credit and debit cards are saved to a patient's account after each transaction, see [Account Module Preferences](693), *Automatically store credit card tokens*.

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**XCharge (OpenEdge)**

In the [Payment](153) window, in the [Credit Card Payment](166) area, click XCharge.

![XCharge Transaction Types](image)

**XCharge Transaction Types**

Select the transaction to process (e.g. Purchase, Return, Void, etc.).

**Transaction Types**: Refer to the XCharge user manual for details on transaction types.
- **Purchase**(166): A standard credit card charge. [Credit Card Payment](166)
- **Return**(190): Credits the amount of the transaction to the card. [Credit Card Return](190)
- **Void**(175): Reverse a sale soon after (same day) it was made. [XCharge Void Payment](175)

**Save Token**: Securely store the credit card number and expiration date as a token for future use. Set the default in [Account Module Preferences](693), *Automatically store credit card tokens*. 
**Prompt for Signature**: Prompt patients for a signature on the credit card terminal before completing transaction. Terminal must support electronic signature capabilities. Set as the default in XCharge Setup (178).

**Print Receipt**: Automatically print a receipt to the default receipt printer when the transaction is completed. Set as default in XCharge Setup.

**XCharge Release**
This window appears after the XCharge Transaction Types when charging a new card or voiding a transaction. Enter the credit card details or swipe the credit card to auto insert the information.

**Toolbar**: Refer to the XCharge user manual for details.

**Clear**: Clears the information entered in the fields below.

**Amount**: The purchase amount entered in the Payment window. To edit, cancel the transaction and enter the correct amount in the Payment window.

**Credit Card #**: Type the credit card number or swipe the credit card to auto-populate this field.

**Expiration (MMYY)**: Type the credit card expiration date. When the card is swiped this field auto-populates.

**Zip Code**: Enter the zipcode of the cardholder's billing address (optional). Some banks require this information and decline the transaction if not entered.

**Address**: Enter the street address of the cardholder's billing address (optional). Some banks require this information and decline the transaction if not entered.

**CVV2/CVC2**: Enter the 3-digit security code from the back of the VISA or MasterCard (optional).

**Receipt #**: Auto-populated by XCharge. This is PAT followed by the patient's ID number assigned by Open Dental (e.g. PAT7453).

**Clerk ID**: The user logged into Open Dental. To edit, cancel the transaction and log into Open Dental as a different user.
[F12] Process: Click to complete the transaction, or select the F12 key.

**EMV Transactions**
To process transactions for credit cards with computer chips (EMV transactions) use XCharge version 8.1.1 or greater and a compatible terminal. Terminal options include:
- Ingenico iSC250 (electronic signature capabilities). Electronic signatures are stored on the workstation that acts as the XCharge server.
- Ingenico iPP320
- Ingenico iCMP (Bluetooth capable)

**Decline Minimizer**
The decline minimizer is a feature that automatically updates expired and outdated card information to reduce declined payments (for participating credit card brands). When a card is automatically updated, the XC Account ID Updated is updated in the payment note transaction details. The patient still needs to be contacted to update the information saved in the Credit Card Manage list.

To add this feature at no additional cost, contact XCharge. No additional set up is required in Open Dental.

**Additional Resources**
XCharge, also known as OpenEdge, is an integrated credit card program that can be used to process credit and debit card transactions. To also process check payments, sign up for the OpenEdge check service.

Website: [https://openedgepayments.com/opendental/](https://openedgepayments.com/opendental/)

United States:
- Sales: 800-637-8268
- Technical Support: 800-338-6614

Canada: 800-338-6614

Note: Make sure to have a back up plan in place for the XCharge server after enabling the service. The XCharge server is not included in the Open Dental manual back up feature.

Related Links:
- XCharge Setup(178)
- XCharge Setup for Clinics(179)
- Credit Card Payment(166)
- Credit Card Return(190)
- XCharge Void Payment(175)
- XCharge Add Card(278)
- Credit Card Transaction Details(188)
- Online Payment Management(1563)
- CC Recurring Charges(1430)
- XCharge Troubleshooting(177)

**XCharge Void Payment**
In the Payment(153) window, click XCharge(173). Select Void from the list of transaction types.
XCharge (OpenEdge) credit card payments or returns can be voided when the original transaction was processed in the last 24 hours and has not been deposited to your account. Voiding removes the original transaction from the patient's bank the same day. If the transaction is older or has been deposited, you can return the payment instead (see Credit Card Return). Returns require a few days to process.

To void a XCharge transaction:
1. In the patient's Account Module, click Payment.  
2. Enter a negative amount (e.g. -50). It must match the original transaction amount. Click OK to open the Payment window.  
3. Clinics: If using Clinics, verify the correct clinic is selected.  
4. Current Payment Splits: Allocate the void's payment split (paysplit) to a procedure or unearned income type.  
   - If voiding a payment that has been allocated: Add a paysplit associated to the original procedure. Check Show All Charges, locate the charge for the original procedure, then click Add Partial and enter a negative split amount.  
   - If voiding a prepayment that hasn't been allocated yet, add a paysplit and assign the unearned type of the original prepayment.  
   - If the original payment was not allocated to a procedure or unearned type, you do not need to create a paysplit.  

If no paysplit is added, an unallocated paysplit will be created.  

Click Search to locate the original transaction.
Highlight the transaction and click OK to fill the X-Charge Release window with the original transaction details.

Click Process or F12 to complete the void, the payment window will automatically close.

The Credit Card Transaction Details will be automatically added to the payment note. Double click the payment to print or email a receipt.

Note: Payments allocated to procedures for multiple family members will post to each patient account.

XCharge Troubleshooting

Below are some troubleshooting steps when using XCharge (OpenEdge)(173).

Problem: After the XCharge (OpenEdge) window is closed, the wrong information goes into the Payment window in Open Dental. For example patient A paid $200 using XCharge and when going to patient B account to make a $150 patient payment it shows patient A's $200 payment.

The correct amount is posting to the accounts, the textual information coming back is from the previous transaction. Do not re-run cards without looking in the XCharge reports.

This is happening because of a problem with the text file used in the bridge. The text file is located in the same place as the Program Path in the XCharge Setup window XCharge Setup(178). The typical path to the text file is: C:\Program Files\X-Charge\XResult.txt. Look for that file.

1. If using the new version of XCharge (requires a username and password) delete the information in the XResult.txt but not the file itself. Otherwise OD will not be able to re-create this TXT file the next time it is run.
2. If using an older version of XCharge that does not require a username and password, the file may be deleted. Make sure the user has full security access to the file's folder.

Problem: When making a patient payment in the Account module, you are required to enter your username and password every time you go to process it.

Check to make sure you have the correct username and password entered in the XCharge Setup window. If that is not the issue, reach out to XCharge. They installed the standalone version instead of the integrated version.

Problem: Receive error Could not delete XResult.txt file. It may be in use by another program, flagged as read only, or you might not have sufficient permissions.

Run Open Dental as the administrator.

Problem: Something went wrong during a claim payment transaction using a prepaid insurance card (Finalize Insurance Payment(231)). How can I determine if the transaction was successful?

In XCharge reports, search for transactions with a receipt number of Prepaid, which indicate they are payments using a prepaid insurance card.
XCharge Setup

In the **Payment** window, right-click on **XCharge**. Select **Settings**.

There are two additional options to access the X-Charge Setup window:
- In the **Main Menu**, click Setup, **Program Links**, **X-Charge from x-charge.com**.
- (first credit card transaction) On the **Payment** window, click XCharge.

To set up different credentials for **Clinics** using different merchant accounts, see **XCharge Setup for Clinics**.

Contact XCharge to install the XCharge client program.

Check the **Enabled** box.

Enter the **Program Path** to the XCharge.exe.

Enter the **Username** and **Password** supplied by XCharge.

Select the Payment Settings:
• Select the default **Payment Type** for XCharge transactions. Customize options in **Definitions: Payment Types** (879). To select a different type for **CC Recurring Charges** (1430) transactions, see **Account Module Preferences** (693), **Payment type for recurring charges**.

• Check **Prompt signature on CC trans by default** to prompt patients for a signature on the credit card terminal before completing transactions. The terminal must support electronic signatures.

• Check **Print receipts by default** to automatically print a receipt to the default receipt **Printer** (601) when a transaction is completed.

• **Recurring charge list force duplicates by default**: By default, duplicate charges to the same card, on the same day, for the same amount will be denied. This is to prevent accidentally charging a card twice. Check this box to allow duplicate charges on the same card by default. Used if family members have recurring charges setup on the same credit card.

• **Prevent saving new cards**: Uncheck to allow users to process new transactions or save new payment information to a patient's account. Check to prevent users from processing new transactions or saving new payment information.

To enable **Online Patient Portal Payments** (1563) and/or **Automatic Recurring Charges** (1430), enter XWeb settings.

• Enter the **XWebID** (12 digits).

• Enter the **Auth Key** (32 digits).

• Enter the **Terminal ID** (8 digits).

• Check the **Enable X-Web for patient portal payments** box (not required if only using Automatic Recurring Charges).

To set whether or not new credit and debit cards are saved to a patient's account after each transaction, see **Account Module Preferences**, **Automatically store credit card tokens**.

**Installing X-Charge with a Terminal**
Below are some points to consider based on a user's experience installing the XCharge server using a terminal.

• Setup may take 1 - 2 hours plus follow-up.

• When you call the XCharge help desk the first time, choose **Install** in the Touch Tone menu (not Tech Support).

• Install XCharge as a Windows Service to prevent accidental shutdown of the XCharge program and/or server.

• If capturing signatures, they will be stored on the workstation in your office that acts as the XCharge server. Make sure you have a backup plan.

• Install the XCharge server on your central server; it does not need to be connected to a terminal. XCharge may want to set it up on a workstation connected to a terminal, but do not do this. This way you can organize your backups to save signatures along with other data on the central server.

• On the terminal:
  o Debit cards have to be swiped and patient will key in the 4 digit pin, even if the cards have chips.
  o When a transaction is complete, a receipt will print (customer's copy). This receipt does not have the signature on it.
  o Completed signatures can only be accessed by running the XCharge utility.

• ISC-250 terminal:
  o It can be customized to display your logo and a short message.
  o If a patient calls in a payment, the card number must be keyed into the terminal. If a workstation only has the XCharge software (and no terminal), the keyboard can be used.

• Staff training is important. The EMV transaction process can be confusing due to the requirements of EMV technology.

**XCharge Setup for Clinics**
Locations using clinics can store **XCharge (OpenEdge)** (173) login credentials for each clinic in a single database, then associate the credentials with different merchant accounts in XCharge.

The XCharge accounts that can be used in Open Dental will depend on the Open Dental security settings for the logged-on user. Users restricted to a clinic can only access the associated merchant account. Users not restricted to clinics (Headquarters) can access all merchant accounts.

There are four steps:
1. Create the clinics in Open Dental. Click Lists, **Clinics** (1505).
2. Add Clinic Merchant Accounts to X-Charge.
3. Create clinic users in XCharge.
4. Set up clinic-level XCharge credentials in Open Dental.

**Add Clinic Merchant Accounts to X-Charge**

Once X-Charge is installed, add merchant accounts for each clinic.

1. In XCharge, go to File, XCharge Server.
2. In the server window, click **Setup...** and enter the administrator's credentials.
3. Click Credit Cards, Connection tab.

4. Add Processor Accounts Information for each clinic in Open Dental that will be using XCharge. For clarity, we recommend using the Open Dental clinic descriptions for the Processing Account Names.

**Set a Default Processing Account for the Headquarters Clinic:** If no clinic is selected for a payment (none), the default merchant account for the Headquarters clinic will be used, as long as the user is not restricted to a specific clinic. To set the default merchant account for headquarters, set the Headquarters processing account as the Default *(Make this Account the Default for this Processor).*
Create Clinic Users in X-Charge
Create clinic users in XCharge for each Open Dental clinic that will process payments with XCharge.

1. Click General Options, Security tab.
2. For each clinic, create an XCharge user with user name and password and select the Processing Account (merchant account) to use with the clinic.
   - We recommend assigning the Open Dental clinic description as the XCharge Processing Account Name and the XCharge User Name.
   - One clinic user must be the XCharge Administrator. This user can process payments using any merchant account.
     We recommend assigning the Administrator user to the Headquarters clinic in Open Dental (see below).

Administrator example: In this example, when the administrator credentials are entered in X-Charge, the user can process payment using any merchant account.
Clinic example: In this setup, when user Clinic2's credentials are entered into XCharge, the Clinic2 processing account will be used thus ensuring all payments for the clinic use the correct merchant account.
Enter Clinic Level XCharge Credentials in Open Dental

For each clinic, in Open Dental enter the XCharge username and password that will be used to log in to XCharge.

1. In the **Main Menu** (592), click **Setup**, then **Program Links** (934), then double-click **XCharge from xcharge.com**.
2. Enter the **Program Path** to the XCharge.exe.

3. Check **Enabled (affects all clinics)** to enable XCharge for all clinics. Unchecking disables XCharge for all clinics. If the currently logged on user is restricted by clinic, only the clinic they have access to will show in the Clinic dropdown and they will not be allowed to uncheck the Enabled box.

4. **Clinic Payment Settings**: Set the payment settings for Headquarters first.
   - Select Headquarters as the clinic.
   - Enter username and password supplied by XCharge (as set in Create Clinic Users in XCharge above).
   - Select the default payment type for XCharge transactions. Customize options in Definitions: Payment Types (879).
   - Check **Prompt signature on CC trans by default** to prompt patients for a signature on the credit card terminal before completing transactions. The terminal must support electronic signatures.
   - Check **Print receipts by default** to automatically print a receipt to the default receipt Printer when a transaction is completed.
   - **Recurring charge list force duplicates by default**: By default, duplicate charges to the same card, on the same day, for the same amount will be denied. This is to prevent accidentally charging a card twice. Check this box to allow duplicate charges on the same card by default. Used if family members have CC Recurring Charges (1430) setup on the same credit card.
   - **Prevent saving new cards**: Uncheck to allow users to process new transactions or save new payment information to a patient's account. Check to prevent users from processing new transactions or saving new payment information.
   - (optional) To enable Online Patient Portal Payments (1563), enter XWeb settings.
      1. Check **Enable XWeb for patient portal payments**.
      2. Enter the XWeb ID (12 digits).
      3. Enter the AuthKey (32 digits).
      4. Enter the Terminal ID (8 digits).
5. Enter payment settings for each clinic. Headquarters settings will be used if clinic-specific changes are not made. For clinics not using XCharge, select the clinic, then clear out the username and password. When the clinic is attached to a payment, the XCharge button will not be visible.

Note: If the Headquarters username and password is the same as one or more other clinics, and the username and/or password is modified for Headquarters, the edits will affect the other clinics as well. To unlink them (assign different usernames/passwords), simply change the username or password for the clinic(s). Then changes made to Headquarters credentials will no longer affect the clinic.

6. Click OK to save settings.

To set whether or not new credit and debit cards are saved to a patient's account after each transaction, see Account Module Preferences (693), Automatically store credit card tokens.

PaySimple

PaySimple is an integrated Credit Card Payment (166) program that can be used to process credit or debit card transactions and ACH payments, direct withdrawal from patient's checking and savings accounts.

In the Payment (153) window, click PaySimple.

![PaySimple Payment Information](image)

Enter the patient's credit/debit or checking/savings account information in the PaySimple Payment Information window.

The PaySimple payment Information window also opens when you click PaySimple on the Edit Insurance Payment Window (231) to process a credit card payment, void, or return and when an account is added to the Credit Card Manage (277) window.

- Note: Deleting a card in Open Dental will also delete the card in PaySimple.
- EMV transactions are not supported for PaySimple.

**Credit/Debit Tab**

Enter a patient’s credit or debit card information in the Credit/Debit tab.

Select the **Transaction Type**. Option not available when adding a card in the Credit Card Manage window.

- **Sale**: A standard credit card charge.
- **Auth**: Add a credit card.
- **Void**: Reverse a sale soon after (same day) it was made.
- **Return**: Reverse a sale one or more days after it was made.

**Card Number**: Place the cursor in the field then swipe the credit card, or type the credit card number.

**Expiration (MMYY)**: Enter the credit card expiration date. When the card is swiped the expiration date will auto-populate.

**Security Code**: Enter the security code from the back of the credit card.

**Name On Card**: Auto-populates with the selected patient’s name, or, when the card is swiped, the cardholder’s name.

**Zip Code**: Enter the zip code of the cardholder’s billing address. When using a card on file, the zip code stored in Credit Card Manage window auto-populates this field.

**Amount**: The amount entered in the payment window. To edit, cancel the transaction and enter the correct amount in the payment window.

**One-Time Payment**: Determines whether a token is created and the card is saved in Credit Card Manage to use again later. Option is only available when adding a credit card while processing a payment.
- Check: Card is used for the current transaction and is not be saved.
- Uncheck: Card is used for the current transaction, a token is created, and the card is saved.

**ACH Tab**

Enter a patient’s checking or savings account information in the ACH tab.

**Account Type**: Select the patient’s account type to be used for direct payment, Checking or Savings.

**Routing Number**: Bank account routing number.

**Account Number**: Bank account number.

**Bank Name**: Name of the bank.
**Amount:** The amount entered in the payment window. If adding the account from the Credit Card Manage window, the Amount field is not visible.

**One-Time Payment:** Determines whether a token is created and the account information is saved in Credit Card Manage to use again later. Option not available when adding a card in the Credit Card Manage window.
- Check: Card is used for the current transaction and is not be saved.
- Uncheck: Card is used for the current transaction, a token is created, and the card is saved.

Note: When an ACH transaction is processed, the payment status will be marked as Posted (pending) in the Payment Note. Once the transaction is settle with the bank, you will need to update the payment amount and status if the payment is declined. To automatically update the payment status (e.g. Settled or Failed), navigate to the PaySimple Setup(1041) program link, re-open and click OK. This one time step will enable automatic status updates. An active registration key and eConnector(1520) is also required.

**Processing a Void**
Payments or returns can be voided when the original transaction was processed in the last 24 hours and has not been deposited to your account. Voiding removes the original transaction from the patient's bank the same day. If the transaction is older or has been deposited, you can return the payment instead. Returns require a few days to process. See Credit Card Return(190).

To void a PaySimple transaction:
1. Locate the transaction you would like to void and in the payment note identify the Ref Number and payment amount.
2. In the patient's Account Module(150), click Payment.
3. Enter the amount of the transaction to void/return as a negative amount (it must match the original transaction amount), then click OK to open the Payment(153).
4. **Clinics:** Verify the correct clinic is selected.
5. **Current Payment Splits:** Allocate voids paysplit to a procedure or unearned income type.
   - If voiding a payment that has been allocated: Add a paysplit associated to the original procedure. Check Show All Charges, locate the charge for the original procedure, then click Add Partial and enter a negative split amount.
   - If voiding a prepayment that hasn't been allocated yet, add a pay split and assign the unearned type of the original prepayment.
   - If the original payment was not allocated to a procedure or unearned type, you do not need to create a paysplit.
   - If no paysplit is added an unallocated paysplit will be created.
6. Click PaySimple to open the PaySimple window.
7. Enter the transaction information, using the same information as the original transaction (PaySimple needs this for verification purposes).
   - Select Void as the Transaction Type.
   - Ref Number
   - Card Number, Expiration Date, and Security Code.
8. Click OK to process, the payment window will immediately close.

**Credit Card Transaction Details**
Credit Card(166) transaction details are added to the Note field of the Payment(153) window when an XCharge (OpenEdge)(173), PayConnect Window(168), or PaySimple(186) transaction is attempted or completed.

**XCharge Transaction Details**
Each transaction type may return different transaction details and the information displayed comes directly from XCharge. A copy of the details are also stored here: C:\Program Files (x86)\X-Charge, XResult.txt for individual transactions and RecurringChargeResult.txt for all the transactions in the last batch of recurring charges run. Every time a transaction is completed the .txt file will be overwritten with the new transaction details.

RESULT=SUCCESS
TYPE=Purchase
APPROVALCODE=101883
AVSRESULT=Y
SWIPED=F
CONTACTLESS=F
CLERK=Tanya  R
XCTRANSACTIONID=85548250673
ACCOUNT=XXXXXXXXXXX1014
EXPIRATION=1220
ACCOUNTTYPE=American  Express
XCACCOUNTIDUPDATED=F
AMOUNT=109.00
APPROVEDAMOUNT=109.00

**Result:** Transaction result (e.g. success, partial, etc.).

**Type:** Transaction type (e.g. purchase, return, void, etc.).

**Approval Code:** Code associated with the approved transaction. Consists of numbers and/or letters. For voids, the approval code will always be 000000.

**AVS RESULT:** Address verification service (AVS) is a service provided by the payment merchant that determines the match or partial match of the card holders address information.

**Swiped:** Indicates whether the card was keyed-in or swiped.
- **F** = False. The card was keyed-in.
- **T** = True. The card was swiped.

**Contactless:** Indicates whether the Tap to Pay option was used.
- **F** = False. The Tap to Pay option was not used.
- **T** = True. The Tap to Pay option was used.

**Clerk:** User who was logged in when the payment was taken. R at the end of the user’s name indicates the card was charged using [CC Recurring Charges](#) (1430).

**XCTransactionID:** XCharge alias assigned to each credit card.

**Account:** Last 4 digits of the credit card used during the transaction. The first 8 (for AMEX) or 12 digits are masked for security purposes.

**Expiration:** Expiration date of the credit card used during the transaction (MMYY).

**Account Type:** Credit card brand (e.g. American Express, Discover, MasterCard, Visa, etc.).

**XC Account ID Updated:** Indicates if the bank sent an updated expiration date, allowing expired credit cards to be charged. See [XCharge (OpenEdge)](#) (173), Decline Minimizer.
- **F** = False. A new credit card expiration date was not received.
- **T** = True. A new credit card expiration date was received.

**Amount:** Requested purchase amount that was entered into the Payment window.

**Approved Amount:** Amount that was charged to the card. This may be different than the Amount if the card holder did not have enough funds to process the entire amount (e.g. partials).
**XCharge Transaction Details - Declined Payments**

Declined credit card payments display less transaction details.

**RESULT=** Transaction not completed

**DESCRIPTION=** 001 Decline

**Result:** For declined cards this will typically display *Transaction not completed.*

**Description:** Reason code for the decline. Refer to the XCharge user manual for code definitions.

**PayConnect Transaction Details**

The transaction details added the payment note by PayConnect.

**Transaction Type:** SALE

**Status:** Approved

**Amount:** 15.00

**Card Type:** VISA

**Auth Code:** XXXX

**Ref Number:** XXXXX

**Transaction Type:** Transaction type (e.g. sale, return, void, etc.).

**Status:** Transaction result (e.g. approved, declined, etc.).

**Amount:** Transaction amount.

**Card Type:** Credit card brand (e.g. American Express, Discover, MasterCard, Visa, etc.).

**Auth Code:** Code associated to the approved transaction consists of numbers and letters. For voids, the approval code will always be 000000.

**Ref Number:** Transaction ID, the same as Transaction # on PayConnect receipts.

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**Credit Card Return**

Refund(194) a Payment(153) back to a credit or debit card using XCharge (OpenEdge)(173), PayConnect Window(168), or PaySimple(186). Refunds cannot be performed directly to a patient's checking or savings account via an ACH transaction. Instead process a check or debit refund. When issuing a Refund, the credit is posted as a negative to the patient account. It may be necessary to apply an Adjustment(203) to remove any procedure balance due after the refund if the patient is no longer responsible.

To return a payment to a credit or debit card, select the patient. In the Account Module(150). Click Payment. Enter a negative amount to return to the card (e.g. -50), then click OK to open the Payment window.

**Clinics:** Verify the correct Clinic(1505) is selected.

**Current Payment Splits:** Allocate the refund to a procedure or unearned income type.

- If refunding a payment that has been allocated, add a payment split (paysplit) associated to the original procedure. Check Show All Charges, locate the charge for the original procedure, then click Add Partial and enter a negative split amount.

- If refunding a Prepayment(191) that has not been allocated yet, add a paysplit and attach the original prepayment.

- If the original payment was not allocated to a procedure or unearned type, add a negative paysplit.

**Note:** If no paysplit is added, an Unearned / Prepayment(191) paysplit will be created.
If this is not a credit or debit card return, enter the check number (if applicable) and select the Payment Type then click OK to complete the return.

If this is a card return, proceed to step 6.

**Credit Card:** Select the credit/debit card to charge or select New Card to enter a new card number.

Click XCharge, PayConnect, or PaySimple to initiate the credit card processor. If multiple card processing programs are enabled, and a card or account is selected, use the program listed next to the number to process the payment. Otherwise, you will be prompted to enter new card or account information.

X-Charge: XCharge (OpenEdge)(173)
1. Select Return as the transaction type.
2. (for new cards) Check Save Token to safely store the card on file then click OK to enter the new card information.
3. Click Process or F12.

PayConnect: PayConnect Window(168)
1. Select Return as the transaction type.
2. (for new cards) Enter the card information and check Save Token to safely store the card on file.
3. Click OK.

PaySimple: PaySimple(186)
1. Select Return as the transaction type.
2. (for new cards or account) Enter the card information and uncheck One-Time Payment to safely store the card on file.
3. Enter the Transaction ID in the Ref Number field.
4. Click OK.

Note: PaySimple does not allow partial refunds. The amount must match the entirety of the original payment.

The Credit Card Transaction Details(188) will be automatically added to the payment note.

**Print Receipt/E-mail Receipt:** Click to manually print or email a receipt. You can also set Open Dental to automatically print or email after a transaction. See XCharge Setup(178) or PayConnect Setup(171).

Click OK to post the return to the patient account.

- Note: Payments allocated to procedures for multiple family members will post to each patient account.
- Cancel will void this return transaction.

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**Unearned / Prepayment**

In the Account Module(150), at the upper right, is the family Unearned Income balance.

Unearned income is typically a prepayment. It's income from a patient Payment(153) to be allocated towards future treatment or an over-payment to be refunded. When a Payment Split’s(161) unearned type is set, the paysplit is considered unearned / prepayment. Prepayments may be allocated to treatment planned procedures at the time of the payment or left as unallocated, and manually allocated when treatment is complete. See Allocate Unearned Income(193).

**Unallocated Prepayment**

Prepayments can be unallocated to indicate payment towards undetermined treatment. When the treatment is complete, you then allocate the prepayment. To instead allocate a prepayment to treatment, see Allocated Prepayment below.

A prepayment not yet allocated to treatment is useful to collect payment in advance for treatment still to be determined.
To create an unallocated prepayment, in the Payment(153) window, verify the Clinic and Payment Type(879). Also, process any Credit Card Payment(166).

Click Prepay. One unallocated paysplit will be created with the default unearned income type, and the payment window will immediately close.

The payment will show as a credit line item in the Account Module(150), affecting the patient's current balance. The family's total unallocated amount will show under Unearned in the top aging bar. Allocate Unearned Income(193) when treatment is complete. Run the Unearned Income Reports(1326) to track accounts with these prepayments.

### Allocated Prepayment

Alternatively, if the prepayment is for a specific treatment planned procedure, allocate the payment to the procedure. For payments to be allocated to treatment planned procedures, you must enable Allow pre-payments to allocate to treatment planned procedures in the Account Module Preferences(693).

To create an allocated prepayment, in the Payment window, click Delete Splits to clear the default payment allocation.

On the Outstanding Charges grid, highlight the treatment planned procedures (TP) and click Pay. Paysplits will be created for each TP procedure selected and be assigned the default treatment planned procedure unearned income type.

Process any Credit Card Payment(166) then click OK to finalize the payment.

The payment will be hidden from the Patient Account tab and most reports, to not affect the patient balance until the treatment planned procedure is set complete. It's also excluded from the Unearned balance since it is already allocated. A summary of the prepayment can be viewed under the Hidden Splits(276) tab. Once the procedure is set complete, the prepayment is transferred to the Patient Account with an automatic Income Transfer(199). Run the Hidden Payment Splits Report(1355) to track accounts with these prepayments.

### Change a Paysplit’s Unearned Type

The default unearned type for unallocated prepayments is Prepayment and for allocated prepayments is Treatment Plan Pre-Payment. Other types can be created in Definitions: PaySplit Unearned Types(880). To assign custom prepayment types as default, see Default unearned type for unallocated paysplits and Default Treatment Planned Procedure Unearned Type in Account Module Preferences(693).

To change the unearned type on a paysplit, re-open the payment and double-click the Paysplit(161).

From the Unearned Type dropdown, select a new type. Unearned types flagged as Do Not Show on Account will be treated as allocated prepayments, even if no TP procedure is attached.

Assign a clinic and provider (optional, Allow prepayments to providers must be enabled in Account Module Preferences). Useful to pay providers on unearned income. If the prepayment is allocated to a TP procedure, the clinic and provider of the procedure is inherited.

Click OK to save changes.
Allocate Unearned Income

In the Account Module(150), select procedures to allocate unearned income, click the Payment dropdown and Allocate Unearned.

The Unearned / Prepayment(191) will be quickly allocated to the selected procedures. This method is useful when you only have one unearned income type to allocate (e.g. prepayment).

Alternatively, do not select procedures and click the Payment dropdown and Allocate Unearned. The Select Procedure(208) window will open and all completed procedures with a patient portion remaining will be listed. Highlight one or more procedures to attach to the payment, then click OK. The Payment(153) window will open.

The Payment Type will be checked as None (indicating this is a transfer of income only). Paysplits for the selected procedures and unallocated amount will be auto-created, offsetting each other to equal 0. Each paysplit will be linked to the original unallocated payment for reporting purposes. Verify that paysplits are accurate.

Note: If the paysplits being created exceed the available amount of unearned income on the account, a pop up warning will display. Decline to correct the amounts entered.

Multiple Unearned Types
If you have more than one unearned income type (e.g. overpayment, copay, etc), use the method below to manually allocate a specific type to a procedure. To allocate unearned payments to enabled repeating charges, assign an unearned income type to the Repeating Charge.(262).

To allocate a specific unearned income type, click Payment and enter a $0 payment.

In the Payment window, check Payment Type, None (indicates a transfer of income).

Create two paysplits to subtract the amount from the unearned income type and add the amount to the procedure.

- First, subtract the amount from the unearned income type: Click Add Split, enter a negative amount, and select the Clinic. Under Payment Split, click Attach to select the unallocated paysplit. The Unearned Type and Provider will automatically change to that of the original prepayment. Click OK to go back to the payment window. Repeat for each unearned income type.
- Then add the income to a procedure: Click Add Split, enter a positive amount, leave Unearned Income Type as None, select the Clinic and Provider to transfer the income to. Under Procedure, click Attach to select a procedure. Under Payment Split, click Attach to select the prepayment used above to link to this procedure. Click OK to go back to the payment window. Repeat for each procedure.

Verify the Total splits equal $0. If they do not, review the paysplits. Both the total amount of the income transfer and paysplits should equal $0.

Click OK to save.

**View Allocations**

Once unearned income has been allocated, you can quickly view the allocations via the original prepayment. If the unearned income is allocated to the wrong clinic, patient, procedure, and/or provider, edit the original allocation (if done same day) or do an Income Transfer(199) to reallocate the income (if the allocation was done in the past).

Double-click the original prepayment.

On the Payment window, click the Allocated tab in the Current Payment Splits grid.

For each allocation, enter the date, amount and patient list.

**Refund**

Process a patient refund by entering a negative Payment(153).
To issue a refund, credit the patient's account for the service. The credit is a negative Adjustment (203) applied to a completed procedure to zero out the fee. Then, either enter a negative payment using the patient's original payment method or apply the payment to other services.

See our video on patient refunds: QuickTip: Patient Refunds

**Patient Refund**

To refund a patient payment:

1. Credit the fee of the procedure to be refunded back to the account. (Skip if refunding an Unearned / Prepayment (191))

Highlight the procedure, click Adjustment and select a negative adjustment type. Click OK to credit the account.

2. Create the refund payment, click Payment and enter a negative amount.

3. Allocate this payment to the procedure or prepayment.
   - To allocate to a procedure, click Delete All to remove the unallocated payment split then highlight the procedure from the Outstanding Charges grid and click Pay.
   - For prepayment refunds, double-click the unallocated split. Under Payment Split, click Attach and select the original prepayment.

4. Process the refund using the original payment method. Select the payment type, enter the check number or for card payments, see Credit Card Return (190). ACH transactions cannot be refunded.

Note: We typically recommend using a payment type of Patient Refund so they can be excluded from the payment reports.

5. Click OK to finalize the refund.

**Account Credit**

An alternative option to a refund is to credit a patient's account and transfer the original payment to other services. After adjusting off the original procedure with a negative adjustment type, complete an Income Transfer (199) to allocate the original payment to other completed or treatment planned procedures.

**Examples**

**Scenario 1:** A service or product return. Your patient purchased a product they want to return.

Add a negative adjustment and attach to the original charge. If the patient is left with a balance, either refund the patient and create a negative patient payment OR leave the credit and complete an income transfer to allocate the payment to other services.

**Scenario 2:** A warranty credit. Your patient paid for a filling that fell out and it needs to be redone. You aren't going to return money to the patient, but you will redo the filling at no charge. Add a negative adjustment to account for the warranty when you chart the replacement procedure.

Once the replacement procedure is complete, create a negative adjustment for the procedure fee and attach it to the new procedure. If a different provider performed the work, consider attaching the adjustment to the original procedure then complete an income transfer to transfer the original payment to the new procedure. This re-allocates the income to the new provider.

**Income Transfer Manager**

In the Account Module, click the Payment (153) dropdown, Income Transfer.
The income transfer manager is used to correct family balances with unallocated payments and transfer overpayments and unearned income to outstanding charges.

When the window opens, any payments not allocated to an unearned type or charge (e.g., adjustments, payment plan charges, procedures) are automatically transferred, immediately updating the items available in the income sources grid. The automatic transfer moves unallocated insurance payments (claims paid using the As Total option) to the claims’ procedures, updating the remaining patient portion for those procedures. Unallocated patient payments are moved to the default unearned income type, making it easier to allocate existing patient income to charges.

Use the income transfer manager to transfer any Unearned Income / Prepayments or income from overpaid procedures to outstanding charges.

1. From the Income Sources grid, select a charge (adjustment, procedure, or payplan charge with a positive ending balance).
2. Select one or more credits (adjustment, procedure, prepayment/unallocated payment with a negative ending balance) to allocate or pay towards the selected charge.

Or, to transfer everything in the list, do not select any income sources.

3. Click Transfer.
   - This creates offsetting negative and positive paysplits under Current Payment Splits.
   - The negative split subtracts the amount from the credit source and the positive split adds the amount to the outstanding charge.
4. Click OK to complete the transfer. If an automatic transfer was created, it is also saved.

- Note: Income transfers require the Payment Create Permission.
- An Audit Trail entry is logged for the automatic transfer.
- When the Account Module Preferences, Enforce Valid Paysplits, Enforce Fully is enabled, some transfers may not be allowed.
Current Payment Splits: List of positive and negative payment splits (paysplits) created to transfer income to outstanding charges.

- Date: Income transfer date.
- Prov: Provider abbreviation.
- Clinic: Clinic abbreviation.
- Patient: First name and last name of the patient.
- Proc Code: Procedure code.
- Type: Abbreviation of the type of charge or credit (e.g. pay plan charges and procedures). Unallocated indicates unearned income (e.g. prepayment) and blank indicates an adjustment.
- Amount: The dollar amount transferred from/to a provider/clinic/patient/charge.
- Total: The total amount of the current paysplits. The income transfer cannot be completed unless the Total is zero.

Delete Selected: Delete the selected paysplits from the grid. The corresponding positive or negative paysplit will also be deleted. The total amount of the deleted split is added back to the Amt End under Income Sources for future transfers.

Delete All: Delete all the paysplits in the grid. All paysplit amounts are added back to the Amt End under Income Sources for future transfers.

Income Sources: List of family adjustments, completed procedures, payment plan charges, and unearned income with a positive or negative ending balance. Positive ending balances reflect amounts owed. Negative ending balances reflect unearned income or overpayments made by insurance or the patient.

Each row is a summary of charges and credits for the same provider/patient/clinic combination. Click the right-arrow next to the provider abbreviation to view the summary breakdown.

- Prov: Provider abbreviation.
- Patient: Last name and first name of the patient.
- Clinic: Clinic abbreviation.
- Codes: Adjustments, payment plan charges, prepayments, and procedure codes available to transfer.
- Amt Orig: Amount owed prior to any payments, adjustments, insurance estimates, and write offs.
- Amt Start: Amount owed after all attached payments, adjustments, insurance estimates, and write offs but excluding the current income transfer.
- Amt End: Amount owed on a charge after all attached payments, adjustments, insurance estimates, and write offs including the current income transfer.
- Total: The total amount of all the selected income sources.

Note: The income sources available for transfer may be different than what shows on the family account; this happens when an automatic transfer of unallocated payments takes place. Since these payments are automatically transferred when the income transfer manager is opened, the procedure ending balances (Amt End) and unearned income totals reflect here first.

Transfer: Transfers selected income sources to selected production sources.

Positive and negative paysplits are created for each transfer of income. The negative split subtracts the amount from the original source. The positive split adds the amount to the new source.

Ok: Post the income transfer as a line item to the patient account, along with the automatic transfer of any unallocated insurance and patient payments. Income allocated to providers/clinics/procedures for multiple family members will post to each patient account.

Cancel: Cancels any changes made in the window. Also deletes the automatic transfer of any unallocated splits.

Transfer Logic

If all items in the income sources grid were selected for transfer, the transfer manager will attempt to allocate any unearned income and negative adjustments to procedures, positive adjustments, and payment plan charges. Income from overpaid procedures is re-allocated to another outstanding charge. All income transferred is applied to the oldest charges with at least one matching provider/patient/clinic combination in the order below.

1. Provider, Patient, and Clinic
For example, if a prepayment/uneearned income amount does not have the exact same provider, patient, and clinic allocation as an existing procedure, payplan charge, or adjustment, the income transfer manager will not allocate the prepayment. It will move on to find the next best matching production source based on the provider and patient, then provider and clinic, and so on until at least the clinic matches. If no provider/patient/clinic combination match is found the payment stays as unearned income.

**Automatic Claim Payment Transfer**

The automatic transfer of unallocated insurance payments is done using negative and positive supplemental claim payments, which are added to each affected claim. To view or delete these transfers, double-click into any received claim that was paid using the As Total option.

Note: Deleting one of the supplemental claim transfers or editing a received claim procedure will delete all of the transfers on the claim. See Supplemental Insurance Payments(237).

The negative supplemental entry is made for the same provider, payment, and write-off amount as the original payment. This subtracts the payment from the claim to re-distribute to the claim procedures.

<table>
<thead>
<tr>
<th>Date</th>
<th>Prov</th>
<th>Code</th>
<th>Tth</th>
<th>Description</th>
<th>Fee</th>
<th>Billed to Ins</th>
<th>Deduct</th>
<th>Ins Est</th>
<th>Ins Pay</th>
<th>Write Off</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
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<td>DOC A</td>
<td></td>
<td></td>
<td>Total Payment</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>211.50</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
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<tr>
<td>01/01/0001</td>
<td>DOC A</td>
<td></td>
<td></td>
<td>Total Payment</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>211.50</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
</tbody>
</table>

The positive supplemental entries add the payment back, allocating it directly to the procedures on the claim. A positive entry is made for each procedure on the claim.

<table>
<thead>
<tr>
<th>Date</th>
<th>Prov</th>
<th>Code</th>
<th>Tth</th>
<th>Description</th>
<th>Fee</th>
<th>Billed to Ins</th>
<th>Deduct</th>
<th>Ins Est</th>
<th>Ins Pay</th>
<th>Write Off</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>11/13/2019</td>
<td>DOC A</td>
<td>D0150</td>
<td></td>
<td>comprehensive oral evaluation - new or established patient</td>
<td>121.00</td>
<td>121.00</td>
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<td>93.60</td>
<td>0.00</td>
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<tr>
<td>Not Final</td>
<td>DOC A</td>
<td>D0150</td>
<td></td>
<td>comprehensive oral evaluation - new or established patient</td>
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<tr>
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<td></td>
<td>prophylaxis - adult</td>
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<td>152.00</td>
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<td>0.00</td>
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<td>0.00</td>
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<tr>
<td>Not Final</td>
<td>DOC A</td>
<td>D1110</td>
<td></td>
<td>prophylaxis - adult</td>
<td>152.00</td>
<td>0.00</td>
<td>0.00</td>
<td>117.90</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
</tbody>
</table>

The insurance payment is split between each procedure on the claim until the payment is completely allocated. It first loops through each procedure and allocates the payment up to the procedures’ insurance and write off estimates. If income is left over, then up to each procedure fee. Anything excess of the procedure fees is added to the first procedure on the claim and may result in an overpaid procedure. Overpayments not refunded back to insurance may be transferred to other charges with a remaining balance through the income transfer manager.

Note: Run the Insurance Overpaid Report(1331) to catch overpayments created by the automatic transfer and process any Insurance Refunds(238) if necessary.

- Overpaid claim procedures transferred through the income transfer manager are done via negative and positive paysplits and show under patient income on reports.
- The date of the supplemental entries is either blank (01/01/0001) or Not Final to signify the entry was created by the automatic transfer but appears on reports as the date of the transfer.
- The supplemental entries do not appear on statements but will appear on Production and Income Reports(1281) and the Daily Payments Report(1294) as a zero line item for the insurance carrier and original payment method, if income was transferred between providers.

**Automatic Patient Payment Transfer**

The automatic transfer of patient payments moves any patient refund, patient payment, or previous transfers of income not allocated to a charge or unearned type (e.g. prepayment) to the default uneearned income type. These negative
unallocated payments are transferred to negative unearned income and positive unallocated payments to positive unearned income. This is done for every family member of the currently selected patient.

If the patient, provider, and clinic combination of the resulting negative and positive unearned income does not match, it may cause excess negative or positive unearned income totals. The excess unearned income re-calculates the family unearned balance and updates the income sources available for transfer in the income transfer manager window. However, if they match, the unearned income cancels out and is not available for transfer. Transfer any excess unearned income to outstanding charges from the income transfer manager.

To view or edit the automatic transfer, click OK on the income transfer manager window then double-click on the Txfr line item in the patient account.

The negative paysplit is for the original amount of the payment, subtracting the payment from its' unallocated state as preparation for the transfer. The positive split completes the transfer by adding or allocating the payment to the default unearned income type. If the Account Module Preferences, Allow prepayments to providers is enabled, the patient, provider, and clinic allocation of the original payment will remain.

- The date of the positive and negative paysplits are the date of the transfer.
- Transfers appear as a blank line item on each affected family member's account and may also appear on their statements if the statement date range includes the transfer date.
- Transfers also appear as line items on production and income reports and the daily payments report as of the transfer date. This does not increase the total income collected but may move the income between patients, providers, and clinics.
- The line item on patient accounts and reports is typically a zero credit but if income is transferred between patients, providers, or clinics the credit amount is the amount transferred.

**Income Transfer**

Transfer or re-allocate income between patients and charges when they are not available in the Income Transfer Manager.

In the Payment Window, at the top, check None (Income Transfer).
To transfer **Unearned Income / Prepayments** (191), see **Allocate Unearned Income** (193) instead.

Create a $0 payment and check the **Payment Type**, **None (Income Transfer)**. When checked, the Pay/Add Partials buttons are replaced with Transfer. If the **Account Module Preference** (693), Enforce Valid Paysplit, is set to **Enforce Fully**, the buttons are replaced with Proc Breakdown.

Note: To view this window automatically after receiving a claim payment, in the Account Module Preferences, check **Show provider income transfer window after entering insurance payment**.

Click **Add Split** or **Proc Breakdown** (see below) to create offsetting negative and positive payment splits (paysplits).

First, add the negative paysplit to subtract the income source from a patient’s clinic and treating provider, or charge.

1. On the **Edit Payment Split** (161) window, enter a negative amount less than or equal to the income source.
   - Less than, to transfer a partial amount (e.g. for an overpayment).
   - Equal to, to transfer the entire amount.

2. Select the Patient with the income source to transfer (defaults to guarantor). Check **Is from another family** to select a patient not in the family list.

3. Select a **Clinic** and **Provider** to subtract the income from. A payment must exist for the selected clinic/provider combination to complete a valid transfer.

Or, click **Attach** to select a charge (one per paysplit). The paysplit will inherit the clinic/provider of the charge.
   - **Procedure tab**: Select a completed or treatment planned procedure (TP).
   - **Adjustment tab**: Select an adjustment.
   - **Payment Plan**: Select the Clinic and Provider assigned to the payment plan, and check **Attached to Payment Plan**. If the family has multiple payment plans, choose the correct plan from the Select Payment Plan window.

4. Click **OK** to save the negative paysplit.

Next, add the positive paysplit to add the income to a different clinic/provider or charge.

1. Enter a positive amount, less than or equal to the negative split.
   - Less than, if adding the income to multiple charges.
   - Equal to, if adding all of the income to one charge.

2. Select the Patient to transfer the income too.

3. Attach the income to a procedure, adjustment, or payment plan (one per paysplit).

Or, select a clinic/provider combination to add the income too, if not transferring to a charge. A charge must exist for the selected combination to complete a valid transfer.

Note: If income is transferred but not allocated to a payplan charge, procedure, adjustment, or unearned type, the next time the Income Transfer Manager is opened, it will automatically be re-transferred to the default unearned type.

4. Click **OK** to save the positive paysplit.

Create additional positive paysplits until the subtracted income is completely allocated. The total added splits must be zero to complete the transfer.
Click **OK** on the Payment window to post the income transfer as a line item to each affected patient’s account.

**Proc Breakdown**
Alternatively, create the paysplits using the Proc Breakdown button (Enforce Fully option). The Pay Split Manager(202) opens to view a list of paid and unpaid charges.

1. Select a charge to subtract the income from. If the Amt End is negative (overpaid) and the desired amount click **Add Splits** otherwise, click **Add Partials** to enter a negative amount.
2. Select a charge to add the income too. If the Amt End is positive (unpaid) and the correct amount click Add Splits. To enter a different amount, click Add Partials.

Repeat until the subtracted income is completely allocated and the total added splits is zero.

Click **OK** on the Pay Split Manager window, then on the Payment window to complete the transfer.

**Transfer Family Balances**
To transfer a patient’s credit balance to another family member, follow the steps below.

Note: When using this method:
- Do not use the Income Transfer Manager or these transfers automatically re-allocate to unearned income.
- It is only recommended if the Account Module Preference, Enforce Valid Paysplits, is set to **Don’t Enforce**.

With None (Income Transfer) as the Payment Type checked, the Outstanding Charges grid groups all charges for the family by clinic and provider.

<table>
<thead>
<tr>
<th>Prov</th>
<th>Patient</th>
<th>Clinic</th>
<th>Codes</th>
<th>Amt Orig</th>
<th>Amt Start</th>
<th>Amt End</th>
</tr>
</thead>
<tbody>
<tr>
<td>DOC A</td>
<td>Cheng, Macy</td>
<td>NW Clinic</td>
<td>D0150, D0210, D1110</td>
<td>585.42</td>
<td>-41.58</td>
<td>-41.58</td>
</tr>
<tr>
<td>DOC A</td>
<td>Cheng, Greg</td>
<td>NW Clinic</td>
<td>D1351, D1351</td>
<td>41.58</td>
<td>41.58</td>
<td>41.58</td>
</tr>
</tbody>
</table>

- The Amt End is the sum of all insurance estimates, write offs, payments, and charges for the clinic/provider combination.
- A negative Amt End indicates an over allocation of payments and/or positive adjustments for the clinic and provider.
- A positive Amt End is the total amount owed to the clinic and provider.

Select the clinic/provider grouping for a patient with a negative Amt End. This subtracts the amount from the selected group to transfer.

Select a grouping with a positive Amt End to add the income too.

Click **Transfer**. Positive and negative paysplits are created for each patient, clinic, and provider allocation.
Click **OK** on the Payment window to complete the transfer. The account balance of each family member included in the transfer increases or decreases by the transfer amount.

<table>
<thead>
<tr>
<th>Patient</th>
<th>Bal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cheng, Macy</td>
<td>-41.58</td>
</tr>
<tr>
<td>Cheng, Greg</td>
<td>41.58</td>
</tr>
<tr>
<td>Entire Family</td>
<td>0.00</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Before</th>
<th>After</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cheng, Macy</td>
<td>0.00</td>
</tr>
<tr>
<td>Cheng, Greg</td>
<td>0.00</td>
</tr>
<tr>
<td>Entire Family</td>
<td>0.00</td>
</tr>
</tbody>
</table>

**Completed Transfers**

Income transfers show as blank payment items with a Txfr code on the Patient Account. Only one, zero credit line item shows if income is transferred from procedure to procedure under the same patient and clinic/provider combination. If income is transferred between multiple patients, and clinics/providers, a Txfr shows for the total negative amount transferred from each patient/clinic/provider combination, and for the total positive amount transferred to each combination.

<table>
<thead>
<tr>
<th>Date</th>
<th>Prov</th>
<th>Clinic</th>
<th>Patient</th>
<th>Proc Code</th>
<th>Type</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>11/18/2019</td>
<td>Macy</td>
<td>DOC A</td>
<td></td>
<td></td>
<td></td>
<td>-41.58</td>
</tr>
<tr>
<td>11/18/2019</td>
<td>Greg</td>
<td>DOC A</td>
<td></td>
<td>NW Clinic</td>
<td>Txfr</td>
<td>41.58</td>
</tr>
</tbody>
</table>

Transfers also show on reports affecting income allocation only; they do not increase or decrease the total practice income.

**Pay Split Manager**

In the **Payment** window, with the amount entered as $0.00 and Payment Type **None (Income Transfer)** checked, click **Proc Breakdown**.

![Pay Split Manager](image)

Use the Pay Split Manager to complete **Income Transfer** when the **Account Module Preferences**, Enforce Valid Paysplits is set to **Enforce Fully**.

**Payment Amount**: The total amount entered on the Payment window (must be zero to complete an income transfer).

**Outstanding Charges**: A list of all procedures, adjustments, and payment plan charges for the family with a positive or negative ending balance. To exclude procedures with a zero balance, uncheck **Show Other Charges**.

- Date: Completed charge date.
- Prov: Provider abbreviation.
- Clinic: Clinic abbreviation.
- Patient: Last name and first name of the patient.
- Proc Code: Procedure code.
• **Type:** Charge description (e.g. Adjustment, PayPlanCharge, or procedure code abbreviation).
• **Amt Orig:** Amount owed prior to any payments, adjustments, insurance estimates, and write offs.
• **Amt Start:** Amount owed after all payments, adjustments, insurance estimates, and write offs but excluding the current income transfer.
• **Amt End:** Amount owed on a charge after all payments, adjustments, insurance estimates, and write offs including the current income transfer.
• **Add Splits:** Click to transfer the income associated to the selected outstanding charges. Payment splits (paysplits) will be created under the Current Payment Splits section.
• **Add Partials:** Click to manually enter the income amount to transfer. If more than one outstanding charge is selected, you will be prompted to enter the amount for each selected charge.

![Enter Amount](image)

**Current Payment Splits:** List of positive and negative paysplits transferred from/to providers, clinics, patients, procedures, adjustments, pay plan charges, etc. Double-click a paysplit to edit.
• **Date:** Income transfer date.
• **Prov:** Provider abbreviation.
• **Clinic:** Clinic abbreviation.
• **Patient:** First name and last name of the patient.
• **Proc Code:** Procedure code.
• **Type:** Abbreviation of the type of charge or credit (e.g. pay plan charges and procedures). A blank column indicates an adjustment. Unallocated indicates unearned income (e.g. prepayment).
• **Amount:** The dollar amount transferred from/to a provider/clinic/patient/procedure.
• **Total:** The total amount of the current paysplits. The income transfer cannot be completed unless the Total is zero.
• **Delete Splits:** Delete the selected paysplits from the grid. The total amount of the deleted split is added back to the Amt End under Outstanding Charges for future transfers.
• **Delete All:** Delete all the paysplits in the grid. All paysplit amounts are added back to the Amt End under Outstanding Charges for future transfers.
• **Add Manual:** Click to manually add a Paysplit (161).
• **Total:** The total amount of all payment splits (must be zero to complete an income transfer).

### Adjustment

In the [Account Module](150), in the toolbar, click Adjustment.
Alternatively:
• In the Account Module, double-click a Procedure(303), and click Add New Adj.
• In a Claim(208), right-click a procedure, and click Add Adjustment. Allow procedure adjustments from claim window must be enabled in Account Module Preferences(693).

Adjustments are used to create additional charges or reduce charges on a patient account. They are always attached to a single patient, provider, and clinic. Additionally, adjustments can be optionally attached to a procedure. Adjustments affect the practice production (see Production and Income(1284)).

Adjustments are also used by the Billing/Finance Charges(1428), Broken Appointments Automation(55), Discount Plans(1230), and Sales Tax(207) tool.

Entry Date: The date the adjustment entry was created. It cannot be changed.
Adjustment Date: Typically the same as the entry date. Modifying this date could potentially change historical data.
(procedure date): The date of the procedure attached to this adjustment.
Amount: The amount of the adjustment.
Provider: Defaults to the patient’s primary provider. Click the dropdown or [...] to select a different provider (only providers restricted to the users clinic will show) or attach a procedure to inherit the procedure’s provider.
Clinic: Defaults to the patient’s assigned clinic. Click the drop down or [...] to select a different clinic (only clinics restricted to the user will show) or attach a procedure to inherit the procedure’s clinic.

If a procedure is attached to an adjustment, or the adjustment is added through the Procedure Info(303) window, the adjustment is assigned to the procedure’s clinic and provider. To give users the ability to change the default clinic and provider assignment see the Account Module Preferences(693), Enforce Valid Adjustments.
Additions: List of adjustment types that add the adjustment amount to the patient's account balance.
Subtractions: List of adjustment types that subtract the adjustment amount from the patient's account balance (issues a credit).

To customize the list of adjustment types, see Definitions: Adj Types(841).

Procedure: Apply or remove the adjustment from a procedure. To set whether or not users are required to associate an adjustment to a procedure, see the Account Module Preferences, Enforce Valid Adjustments.
- Click Attach to select a completed procedure. The Select Procedure(208) window will open.
- Click Detach to remove an associated procedure.

Edit Anyway: Allows user to change the provider and clinic. Button is only visible if Enforce Valid Adjustments, Enforce Fully Account Module preference is enabled and the user has the Setup security permission.

Note: Enter any notes about the adjustment. To show these notes on statements, see Manage Module Preferences(744).

Delete: Remove the adjustment from the patient's account.

OK: Save changes made to this window. If the adjustment is attached to a procedure and the amount exceeds the procedure's remaining balance, clicking OK will prompt the user with an Overpaid Procedure Warning.
Cancel: Close the window without saving any changes.

To determine behavior and logic of adjustments, review other preferences in Account Module Preferences and Appointments Module Preferences(608). Use the Daily Adjustments Report(1292) to report on custom types.

Add Multiple Adjustments
To create multiple adjustments attached to multiple procedures at once, use Add Multiple Adjustments(205).

Add Multiple Adjustments
In the Account Module(150) toolbar, click the Adjustment(203) dropdown and select Add Multiple.
Use the Add Multiple Adjustments window to add an adjustment for multiple procedures at once.

Alternatively, open the Add Multiple Adjustments window from the Account module:
- Highlight multiple procedures, click the Adjustment dropdown and select Add Multiple.
- Highlight multiple procedures, then right click and select Add Adjustment.

**Date:** Typically the same as the entry date. Modifying this date could potentially change historical data.

**Amount / Percent:** The amount of the adjustment to attach to the selected procedure. Select a radio button to further define the adjustment amount.
- Fixed Amount: Each adjustment will be fixed dollar amount.
- Percent of Remaining Balance: Each adjustment will be a percentage of each procedure’s unpaid portion (Ins Est + Pat Port) - (Ins Paid - Write-off).
- Percent of Fee: Each adjustment will be a percentage of the attached procedure’s fee (does not consider insurance write-off).

**Provider:** Provider assigned to the adjustments. Defaults to inherit the provider on the attached procedure. Click the dropdown or [...] to select a different provider. This will affect the production of the provider.

**Clinic:** Clinic assigned to the adjustments. Defaults to inherit the clinic on the attached procedure. Click the dropdown or [...] to select a different clinic. This will affect the production of the clinic.

Note: When Enforce Valid Adjustments, *Enforce Fully* is enabled in Account Module Preferences(693), provider and clinic can not be overridden here. Instead, edit each adjustment from the patient account.

**Additions:** List of adjustment types that will increase the procedure fee. Customize options in Definitions: Adj Types(841).

**Subtractions:** List of adjustment types that will decrease the procedure fee. Customize options in Definitions, Adj Types.
**Available Procedures**: A list of the available procedures to attach the adjustments to. To filter the list, use the Credit Filter radio buttons. The default filter is based on the Account Module Preference enabled for Enforce Valid Adjustment.

- **Only allocated credits**: Show all procedures that do not have enough attached credits (e.g. paysplits, adjustments) to cover the full cost of the procedure (e.g. procedures that have attached paysplits that only cover part of the cost).
- **Include all credits**: Show all procedures that are not paid off using first in/first out logic. This logic applies when credits in a payment are not explicitly attached/allocated to procedures.
- **Exclude all credits**: Show all procedures on this patient's account.

**Note**: Custom text that appears on each adjustment. To show this note on statements enable the [Manage Module Preference](744), [Show notes for adjustments](744).

**Add Adjustments**: Click to create an adjustment for the selected procedures with the Adjustment Info and Note.

**Delete**: Delete the highlighted adjustments from the Available Procedures with Adjustments grid.

**OK**: Save changes and post the adjustment to the patient's account. If the adjustment is attached to a procedure and the amount exceeds the procedure's remaining balance, clicking OK will prompt the user with an **Overpaid Procedure Warning**.

**Cancel**: Close the window without saving any changes.

---

**Sales Tax**

In the **Adjustment** (203) dropdown, an Apply Sales Tax option can be used.

![Adjustment](image)

In the **Account Module** (150), sales tax can be quickly added to the patient's account by applying a sales tax adjustment to selected procedures based on a set percentage.

**Note**: To quickly add retail items (e.g. toothpaste) to a patient's account, see [Quick Procs](261).

**Setup**: In **Account Module Preferences** (693):

- Set the default adjustment type for sales tax adjustments.
- Set a fixed sales tax percentage.

**Apply the Sales Tax to Procedures**:

1. In the Account module, select the procedures to apply the sales tax to.
2. Click the Adjustment dropdown in the toolbar, then Apply Sales Tax.

For each procedure, a Sales Tax adjustment will be added. Below is an example of a 5% sales tax adjustment for a $5 procedure.

<table>
<thead>
<tr>
<th>Date</th>
<th>Patient</th>
<th>Code</th>
<th>Description</th>
<th>Amount</th>
<th>Balance</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/10/2017</td>
<td>Maureen</td>
<td>Albert</td>
<td>Toothpaste, Adj: $0.25, Pat Port: $5.00</td>
<td>5.00</td>
<td>309.80</td>
</tr>
<tr>
<td>01/10/2017</td>
<td>Maureen</td>
<td>Albert</td>
<td>Adj</td>
<td>0.25</td>
<td>310.05</td>
</tr>
</tbody>
</table>

The default provider on the adjustment will be the [Practice](931) default provider. For [Clinics](1505), the default provider will be the default provider for the clinic assigned to the procedure, or if no clinic, the practice's default provider.
Select Procedure

In the Edit Adjustment(203) window, click Attach.

Alternatively, when an account has unearned income, click Allocate Unearned(193) in the payment dropdown from the Account Module.

Credit Filter: There are three options to filter the procedures.

- **Only allocated credits**: Show all procedures that do not have enough attached credits (e.g., paysplits, adjustments) to cover the full cost of the procedure (e.g., procedures that have attached paysplits that only cover part of the cost).

- **Include all credits**: Show all procedures that are not paid off using first in/first out logic. This logic applies when credits in a payment are not explicitly attached/allocated to procedures.

- **Exclude all credits**: Show all procedures on this patient's account.

Breakdown: Highlight one or more procedures to see the breakdown of fees, adjustments, paysplits, payments, and write-offs.

Claim

In the Account Module(150) toolbar, click New Claim, or double-click an existing claim to edit.
Alternatively: select a [Claim Type](228) from the [New Claim](228) dropdown menu.

- This will automatically create a claim for all procedures not billed to insurance without selecting any procedures. If there is dual coverage, a secondary claim is automatically created with a status of [Hold until Pri Received](228).
- For more control, highlight specific procedures, then click [New Claim](228), or click the drop down to create a Primary, Secondary, Supplemental, or Other claim type.

Once created, the claim will show in the patient’s account under the procedures.
To send, print, edit, or delete a claim, the logged-on user must have the correct security permissions. This window is read-only if the logged-on user doesn’t have access to the clinic on the claim or the clinic on the claim is hidden.

- **Note:** When a patient has Unearned / Prepayment (191) and the Account Module Preferences (693) Prompt user to allocate unearned income after creating a claim is checked, the user is prompted to Allocate Unearned Income (193) when a claim is created.
- Editing a claim with supplemental claim transfers created by the Income Transfer Manager (195) will delete all the transfer entries on the claim. See Supplemental Insurance Payments (237).

**Claim Status:** Every claim has a status.
- **Unsent:** Claim has been created, but not sent.
- **Hold until Pri received:** For secondary claims that should not be sent until the primary claim is received.
- **Waiting to Send:** Claim is ready to be printed or sent electronically. See Send Claims (489).
- **Probably Sent:** Claim has been printed or sent electronically, but the process has not yet been verified. As soon as you are sure the claim has been sent or printed, change its status.
- **Sent - Verified:** Claim has been sent or printed. It will show on the Outstanding Insurance Claims Report (1315) so that you can track it and make sure it gets paid in a timely manner.
- **Received:** Claim has been received from insurance, either with a payment or denied for some reason. Usually the claim is marked received automatically when you click one of the Enter Payment buttons at the upper right.

When you create a claim for a patient with dual coverage, both a primary and secondary claim are automatically created. The primary claim will have a status of Waiting to Send. The secondary claim will have a status of Hold until Pri received and will stay in the patient's account. When the primary claim is received send the secondary claim (verify the estimates on the secondary claim before sending).

- **Note:** For information about secondary claims, see Secondary Insurance (132).
- If sending a secondary claim using ClaimConnect (656) and NEA Fast Attach, any attachments (e.g. the EOB), need to be uploaded to NEA and documented in Open Dental before sending the claim. See Electronic Attachments (227).
- Claim text color is dependent on settings in Definitions: Account Colors (838).
- Printing a claim automatically changes its status to sent.

**Claim Type:** Set automatically when you create the claim. It is there for reference, but you are not allowed to change it because it affects so many other fields. See Claim Types (228).

**Date of Service:** Defaults to the date of the earliest procedures attached to the claim.

**Date Orig Sent:** The date the claim was originally sent.

**Date Sent:** Populates with the date the claim was created, and updates when the claim is sent. When a claim is resent, the label changes to Date Resent and the date is updated.

**Date Received:** The date the claim was received and processed.
Resend: Resend a claim. This message will show.

![Resend Claim](image)

If you choose the first option, the claim Correction Type (*Edit Claim - Misc Tab*) will be set to Original, the Date Resent will be set to today's date, then the claim will be sent electronically. If the second option is chosen, the Correction Type will be set to Replacement, then the claim will be sent electronically.

**Clinic:** This will match the clinic assigned to procedures in the claim.

**Med/Dent:** There are three options; Dental, Medical, and Institutional. The default selection is based on the claim type. This setting is used for e-claims and determines whether the e-claim format is dental, medical, or institutional.

**Claim Form:** The default claim form (*Claim Forms*)). To change, click the dropdown. For information on how a printed 1500 claim form is populated, see *HCFA 1500 Claim Form*. For information on how a printed ADA 2012 claim form is populated, see *ADA 2012 and 2018 Claim Forms*.

**Billing Provider:** The default billing provider follows the logic below.
- If the treating provider has a Claim Billing Prov Override, that provider is used (*Provider*).
- Otherwise, for clinics, if the procedure is assigned to a clinic, the Default Insurance Billing Dentist for that clinic is used (*Clinic List*).
- Otherwise, the Default Insurance Billing Dentist for the practice is used (*Practice Setup*).

You can also assign a different provider for each procedure. When providers are restricted to specific clinics (*User Edit*), only providers available for the claim's clinic are options.

**Treating Provider:** By default is the last provider in the list of selected procedures who is not flagged as a secondary provider. If there are only providers flagged as a secondary provider, then it will be the patient's primary provider. Some claim formats require a treating provider. You can still assign a different provider for each procedure. When providers are restricted to specific clinics, only providers available for the claim's clinic are options.

**Predeterm Benefits/Preauthorizations:** If you have previously sent in a *Preauthorization*, enter the number received from insurance. In older versions there was a single PreAuth Number field. In newer versions, this is renamed Predeterm Benefits. This number shows on e-claims and printed claims (PreAuthString). On the Misc tab there is also a Prior Authorization (rare) field (see below).

**Insurance Plan:** Set when you create the claim and cannot be changed. If you attach the claim to the wrong insurance plan, delete the claim, then recreate it.

**Relationship:** The patient's relationship to the plan's subscriber, based on the value set in the patient's Edit Insurance Plan Window.

**Other Coverage:** If there are multiple insurance carriers, this auto-populates. For instance, if the claim is to the primary insurance, and the patient also has secondary coverage, the secondary coverage shows. Click Change to select a different plan. Click None to remove this information from the claim.

**Enter Payment:**
- **As Total:** Receive a claim as a total payment amount.
- **By Procedure** (recommended): Receive a claim by itemizing the payment by procedure.
- **Supplemental:** Enter additional payments on procedures already marked received. See *Supplemental Insurance Payments*.
- **Split Claim:** Split the procedures on the claim into two separate claims. See *Split Claim*.
Procedures: The procedures attached to this claim, along with billed fees and insurance estimate information. Double click a procedure to see details. See Receive Claim(229) for a description of each column.

- **Add adjustment**: Right click on a procedure to create an adjustment. The Account Module Preferences(693), Allow procedure adjustments from claim window must be enabled.
- **#: The number of the procedure as ordered in claim.**
- **Date**: Service date of procedure.
- **Prov**: Treating Provider associated with procedure.
- **Code**: Procedure code.
- **Tth**: Tooth number for associated procedure.
- **Description**: Procedure description.
- **Fee**: Procedure Fee.
- **Billed to Ins**: Fee amount billed to insurance.
- **Deduct**: Deductible.
- **Ins Est**: Estimate Insurance payment.
- **WriteOff**: Amount of writeoff for procedure.
- **Status**: Current claim status of the procedure. I.E.: Sent, Recd (Received), etc.
- **Pmt**: Payment. An "X" indicates a finalized payment has been entered for this procedure.
- **Pay Tracking**: Claim Payment Tracking status from Claim Status History(219).
- **Remarks**: Remarks from EOB.

Recalculate Estimates: Recalculate benefit estimates. For example:

- If you treatment plan procedures with the wrong percentages and create a claim before fixing the percentages, recalculate instead of deleting the claim.
- If a fee schedule was originally incorrect, recalculate write-offs.

Note: An orange exclamation mark will appear next to the button when recalculation of claim estimates is suggested.

Medical claims: The Ins Est column can be misleading if the patient has one dental insurance plan listed first and one medical insurance plan listed second. In this particular situation, the Ins Est column will always say 0, because it is showing the dental insurance estimates. To avoid this issue, ensure that the medical plan is listed first in the Family module. See Medical Insurance(128).

There are limits to the number of procedures that are sent with a claim.
- Dental and medical e-claims are limited to 50 procedures. If you attach more, you will be blocked from sending the claim.
- Institutional e-claims are limited to 999 procedures.
- On printed claims, only as many procedures as will print on a single page (the claim form) will be sent. The printed ADA 2012 claim form is limited to 10 procedures.

View ERA: Access ERAs(568) associated with the claim. ERAs can only be accessed when claim identifiers and service dates match.

View EOB: View scanned EOBs for attached insurance payments. If there are more than one a selection list will appear.

Batch: Attach received claims to a batch insurance payment. See Finalize Insurance Payment(231).

This Claim Only: Attach a received claim to a single insurance payment.

Reasons Underpaid: Enter details if a claim does not pay as much as expected, enter details about why. This information shows on the patient's statement so they know why they have to pay more for their procedures.

General Tab: Enter information about prosthetics, orthodontic work, and claim referrals. See Edit Claim - General Tab(213).

Attachments Tab: Enter information about attached images and documents. See Edit Claim - Attachments Tab(214).

Misc Tab: Enter information about Denti-Cal and other miscellaneous fields. See Edit Claim - Misc Tab(218).
Medical Tab: Enter information printed on medical claim forms, including the UB-04, which is usually for institutional claims. See Edit Claim - Medical Tab(219).

Status History Tab: Record custom claim tracking data. See Edit Claim - Status History Tab(219).

Delete: Delete a claim.

Label: Print a label for the claim.

Preview: Preview the claim as it would look on the printed claim form.

Print: Print the claim.
Note: Printing a claim automatically changes its status to sent.

Send: Send the claim electronically.

History: The electronic claim message (x12).

OK: Save the claim information.

Cancel: Close the window without saving.

Edit Claim - General Tab
In the Claim Edit(208) window, click the General tab.

In the general tab you will find fields for prosthetics, orthodontic work, claim referrals, and claim note.

Crown, Bridge or Denture: For bridges, dentures, and partials, Missing Teeth(323) must have been correctly entered in the Chart module. If Replacement is selected, a Prior Date is required. This information only shows on printed claims and is not sent electronically. To send this information electronically, enter on the Procedure Info window(303) (Prosthesis Replacement, Original Date).

Place of Service: The service location. Defaults to the Place of Service on the last procedure in the claim (as set on the Procedure - Misc Tab(315)). If Public Health(71) is turned on, the default is based on the site’s default place of service (Site List(1272)).
- Sent in dental 5010 e-claims only.
- Changing place of service here will change the Place of Service on all procedures on the claim.
- Usually set to Office. Exceptions: certain procedures to specific insurance carriers (e.g. Medicaid), sometimes when using clinics.

Accident: Used to indicate that dental treatment was needed as the result of an accident.
• **Accident Related:** The type of accident. Shows on printed claims in the following fields (depending on the value chosen): IsOccupational, IsNotOccupational, IsAutoAccident, IsNotAutoAccident, IsOtherAccident, IsNotOtherAccident, IsNotAccident, IsAccident, MedAccidentCode.

• **Accident Date:** Shows on printed claims and e-claims. On printed claims, shows in the AccidentDate field.

• **Accident State:** Shows on printed claims in the AccidentST field and on e-claims for auto accidents.

**Ortho:** Only used for ortho claims.

• **Is for Ortho:** Affects the IsOrtho and IsNotOrtho fields on printed claims. If the checkbox is marked, then Months Remaining is reported on e-claims (in Canada the ortho flag is sent electronically instead). Checked by default if claim includes an orthodontic procedure and in Ortho Setup(927)Mark claims as Ortho if they have ortho procedures is checked.

• **Date of Placement:** Shows on printed claims and dental e-claims. On printed claims, shows in the DateOrthoPlaced field. If *Use the first ortho procedure date as Date of Placement* is checked in Ortho Setup, the date of the first orthodontic procedure on the claim auto-populates the field.

• **Months Total:** Enter total months sent in 5010 e-claims.

• **Months Remaining:** Shows on printed claims in the MonthsOrthoRemaining field if the value is greater than zero.

**Claim Referral:** Only enter a referring provider and referral number if it is required by your insurance carrier.

• **Referring Provider:** Click select to attach a referring provider from an existing list, or add a new Referral. Click None to clear the field. Click Edit to enter notes or change information about the selected provider.

• **Referral Number:** Provided by your insurance carrier. Do not put NPI numbers here; NPI numbers must be entered on the Edit Referral window. If an NPI number is missing, it will cause a claim rejection.

**Claim Note:** A claim level note that shows on printed claims and e-claims. The claim note and attachment ID Number together are limited to 400 characters. If a procedure in the claim has a default claim note, it will automatically copy to this field when the claim is created. If multiple procedures have default claim notes, each note will added. Enter a procedure's default claim notes on the Procedure Code(1200).

**Edit Claim - Attachments Tab**

Use the attachments tab to document which attachments will be sent with the claim and how they will be sent.

In the Claim Edit(208) window, click the Attachments tab.

**NEA/Manual Tab**
The NEA/Manual Tab is used to document attachments sent to NEA Fast attach or other third party services. The information documented here is informational only.

This box will be grayed out if Allow Attachments is selected in your clearinghouse setup.

**Radiographs, Oral Images and Models**: Enter how many pages will be sent for each. This information shows on paper claims and e-claims.

**EOB, Narrative, Perio chart, Misc Support Data**: Check the items that will be sent with the claim. This information shows on e-claims.

**By Mail/Electronically**: Select how the attachments will be sent.

**Attachment ID Number**: If you have an attachment ID that must be included before sending the claim, copy it, then paste it here. The ID will be prepended to the notes field and will also go out on the e-claim in a special field for attachments. If using NEA FastAttach with ClaimConnect, the NEA# will be inserted into the claim after the claim has been sent. See [Electronic Attachments](#).

**Attached Images**: Select the images that will be sent as attachments, then export them to a temporary folder.
- Click **Add** to select an image from the Images module.
- Click **Perio** to attach the current perio chart including up to 5 historical measurements. See [Perio Chart](#).

As you add images, they will list in the box.
- Double-click on any attachment to view the image.
- Right-click to open, rename, or remove.
- Click **Export** to send all listed attachments to the folder defined in [Account Module Preferences](#), [Claim Attachment Export Path].
- Import the images from the temporary folder to the attachment service (e.g. to NEA Fast Attach).

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**DXC tab**

See [DentalXChange Attachment](#)

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**DentalXChange Attachment**

Attachments can be sent electronically through the DentalXChange (ClaimConnect) clearinghouse.
In the **Edit Claim - Attachments Tab** (214), click the DXC tab.

Enable the DentalXChange Attachment service in **ClaimConnect E-Claims** (656) prior to sending attachments.

**Attachment ID**: An attachment ID will automatically populate when attachments are sent. DentalXChange will use the attachment ID to associate attachments to the claim.

Click **Add Attachment** to open the Claim Attachments window. A warning will pop up to ensure all changes to the claim have been saved first.

Note: For a new **Claim** (208), clicking **Send** or **OK** in the Edit Claim window will validate the claim. If an attachment is needed, you will receive a popup asking to add the attachment.

Click **Add Image** to attach an existing image from your File Explorer, or click **Snipping Tool** to create a screenshot of an image (see below).

- Note: PDF files are not supported by the DentalXChange Attachment Service.
If no Image Category (869) is selected for Attachments, a warning will appear stating the first image category listed will be used.

You can add as many attachments as needed. If the service times out, attachments will be sent one at a time until all have been sent.

**Narrative**: Enter a narrative (optional). Allows up to 2,000 characters.

**Claim Validation Status**: Will list any errors or validation notes for the attachments.

As each image is added, the following window will appear:

- **File Name**: Give the image a file name.
- **Date Created**: This field will auto-populate with today's date. Change the date if needed.
- **Image Type**: Select from:
  - Referral Form
  - Diagnostic Report
  - Explanation of Benefits
  - Other Attachments
  - Periodontal Chart
  - X-Rays
  - Dental Models
  - Radiology Reports
  - Intra-Oral Photographs
  - Narrative

- **Image Orientation Type**: Only shows when X-Rays is selected. Select RIGHT or LEFT.
  Click OK to save image information.

Once attachments have been sent, return to the Edit Claim window and send the claim. Attachments will automatically save in the patient's Image Module.

**Snipping Tool**
Use the snipping tool to grab a screenshot of an image if one does not already exist. This is useful to quickly grab an image without exporting and saving it first.
1. Click **New** to create a new image.
2. Click and drag the red box over the selected area.
3. Click **OK** to save the image, or click **Cancel** to try again.

Note: If you have Windows Scaling turned on, or you are using a remote application, the Snipping Tool will not work. Instead, use the Windows Snipping Tool and save the file outside of Open Dental. Once saved, add the attachment manually.

**Edit Claim - Misc Tab**

In the Claim Edit (208) window, click the Misc tab.

In the Misc tab you will find fields that apply to **Denti-Cal** (660) and other fields that are not used often.

**Correction Type:** In e-claims this field corresponds to the Claim Frequency Code and is used to fix mistakes on e-claims that have already been sent. It was added for Denti-Cal direct integration, but can be used for other carriers as well. There are three possible correction types.

- **Original:** Select this type for the first submission of any e-claims. Sends a value of 1.
- **Replacement:** Select this type if you realize, after submitting an e-claim, that some of the reported information is incorrect. Then resend the claim. The carrier will ignore the original claim and instead use the new replacement claim. Each carrier has their own policy on whether or not they accept replacement e-claims and what kinds of corrections they will allow. Contact the carrier for their policy. Sends a value of 7.
- **Void:** Select this type if an e-claim was sent entirely in error, then resend the e-claim to cancel the original claim. Most carriers do not support this correction type. Sends a value of 8.

To improve chances of acceptance, send Replacement and Void claims as soon as possible after the original claim is sent.

**Prior Authorization (rare):** Typically used for medical claims. Shows on printed and e-claims. On printed claims, the number shows in the PriorAuthorizationNumber field.

**Special Program:** Only used for e-claims in the 5010 format. This is sent on preauthorizations when the value is set to a something other than none.

**Default Claim Identifier:** A unique identifying number for each claim. Open Dental automatically generates this number. By default, the PatNum is used as the prefix. To select a different prefix, change the **Claim Identification Prefix** under Account module preferences.

**Claim Identifier (CLM01):** A unique identifying number for each claim. Open Dental automatically generates this number.
using the format PatNum/ClaimNum. It can be manually edited when creating the claim, but once the claim is saved it cannot be changed. It is used to match ERAs (668) to the original claim.

**Original Reference Num:** Required by insurance when voiding a claim or replacing a claim by setting the CLM05-3. This number is given by the insurance.

**Share of Cost Amount:** Rarely used. It is the sum of all amounts paid specifically to this claim by the patient or family. Sent in e-claims.

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**Edit Claim - Medical Tab**

In a Claim (208), click the Medical tab.

Medical tab shows information for medical claims. Only enter information on this tab if you are sending a medical claim. It is only visible if Medical Insurance (128) is turned on.

**Ordering Provider Override:** Set a general ordering provider override for procedures on this claim. This override will only be assigned to procedures on the claim that do not have an override set on the procedure level (Procedure - Medical Tab (314)). By default, there is no override and the treating provider is used. See E-Claims Complexities (496), Ordering Provider, for the logic.

- **Internal:** Select a provider from the Providers (1252).
- **Referral:** Select a provider from the Referral List (1268).
- **None:** Clear the override.

**UB04:** The UB04 is typically used for institutional claims (e.g. hospitals or outpatient facilities). The claim forms are printed; they are not sent in e-claims. Check with the insurance company to verify the values they accept for each of the values in this section.

Information on codes used on a UB04 claim cannot be published by Open Dental and is owned by the American Hospital Association.

**Printing:** It is helpful to have a background image for setup purposes. The background image should not print because preprinted forms should be used. To see the background, save the file UB04.jpg in your A to Z Folder (826), then add it to the claim form (Claim Forms (641)).

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**Edit Claim - Status History Tab**

In the Claim Edit (208) window, click the Status History tab.
Use the Status History tab to record data about a claim.

For example, track why a claim is not sent, why processing may be delayed, etc. Log entries are created each time claim status changes.

- Customize claim custom tracking status options in Definitions: Claim Custom Tracking (857) and set the None default status option in Account Module Preferences (693). Statuses can optionally have a days suppressed value so that a claim is excluded from the Outstanding Insurance Claims Report for a certain number of days after a status change.
- Customize Error Codes in Definitions: Claim Error Code (858).
- To update status for many claims at once, see Outstanding Insurance Claims Report (1315).

This information does not show on printed claims or e-claims.

**Add a Custom Track Status / Error Code**

1. Click Add.

2. **Custom Track Status**: Click the dropdown to select a status.

3. **Error Code**: Click the dropdown to select an error code. The long description of the error code displays in the text box below the dropdown.

   Note: To require an error code, check the preference in Family Module Preferences (637).

4. **Note**: Optionally add a note that will show in the Log Note column. Right-click to insert Quick Paste Notes (1088). Notes can be added or edited later by double-clicking on claim tracking status.

5. Click Update to save.
Claim Procedures (claimprocs)

In a Claim, double-click on a procedure.

Alternatively, in the Procedure - Financial Tab double-click an estimate.

A claim procedure (claimproc) is used for the following purposes:
- To attach procedures to claims.
- To split insurance payments on claims.
- To record total insurance payments on claims. These payments are not attached to procedures.
- To store insurance estimates before a claim is created.

In a typical situation:
1. While treatment planning, a procedure is created.
2. A claimproc is automatically added to the procedure to keep track of its estimated insurance portion. Change the estimate by changing the claimproc.
3. When the claim for the procedure is created, the claimproc links the procedure to the claim.
4. When viewing the claim detail, all procedure estimates and payments are stored in the claimproc rather than with the procedure. This allows you to send an unlimited number of claims for each procedure and to have very fine control over all estimates and payments for each claim.
5. When receiving a claim, it can be itemized by procedure or entered as a total payment.
Change the information as needed, then click OK to save. The logged-on user must have the correct security permission to edit write-offs and write-off estimates.

**Ins Plan:** The insurance plan and subscriber. Claim procs are always associated with one insurance plan whether they are an estimate or attached to a claim.

**Status:** The status of the claim procedure.
- **Estimate:** Not yet attached to a claim. Claim info in lower right will not be visible. Estimates never affect the patient balance.
- **Not Received:** Attached to a claim with a *Waiting or Sent* status.
- **Received:** Attached to a claim with a *Received* status. Should also be attached to an insurance payment (finalized).
- **PreAuthorization:** Attached to a *Preauthorization* (293).
- **InsHist:** Procedure was created by adding a date to *Insurance History* (136).
- **Supplemental:** Indicates an additional payment on the same procedure. Much of the estimates will be 0. Almost identical to Received.
- **For Capitation (HMO / DMO) Insurance Plan** (120), the statuses below apply:
  - **CapClaim:** Since most capitation procedures are not sent to insurance there will always be duplicate claim procs for a procedure (similar to Supplemental). The first claim proc tracks the co-pay and write-off and is never attached to a claim (status = CapComplete). The second claim proc has status of CapClaim.
  - **CapEstimate:** Not yet attached to a claim or for a procedure that is treatment planned (TP). When procedure is completed, status can be changed to CapComplete but never to anything else.
  - **CapComplete:** Only set when procedure is set complete. This stores the co-pay and write-off amounts. The co-pay is only there for reference; the write-off affects the balance. Never attached to a claim.
  - **(Adjustment: A hidden type set in the upper section of the Insurance Plan** (81) using a completely different interface.)

**Payment Tracking:** Document information about the payment of the procedure. Useful to track why payment was rejected. Customize options in *Definitions: Claim Payment Tracking* (861).

**Provider:** The provider who performed the procedure. Click [...] to change. The provider can only be changed when the status is set to *Not Received*.

**Clinic:** The associated clinic. Only visible if *Clinics* (1505) is turned on.

**Pay Entry Date:** The date the related insurance payment was entered. Used to track account aging.

**Payment Date:** Can be edited.

**Procedure Date:** The date the procedure was performed. Used to track annual benefits used.

**Description:** The procedure code description.

**Claim:** Indicates if this claim proc is an estimate or has been attached to claim. If part of a claim, the following information shows:
- **Code Sent to Ins:** The procedure code sent to insurance. Usually it is the same as the actual procedure code, but may be different if using alternate codes (e.g. for Medicaid), medical codes or custom codes with suffixes that get removed before being sent.
- **Fee Billed to Ins:** The amount billed to insurance. Usually it is the same amount you billed the patient, but does not need to be. If *Claims show UCR fee* is checked on the Edit Insurance Plan window, the amount shown is the provider's UCR fee. So the claim may go out with a fee of $105, but the patient will only be billed $100.
- **Remarks from EOB:** EOB remarks that explain why insurance did not pay as expected on this procedure.

**Do Not Bill to Insurance:** Only used when the claim proc is an estimate. Indicates that this claim proc will remain an estimate and never be attached to a claim.

**Estimate Information:** Located at the top right. Changing information will not change the patient's balance.

Note: Be aware that manually entering overrides will not fully recalculate insurance coverage. For example: adding a missing coverage percentage will not result in a missing deductible being added. Whenever possible, it is best to correct coverage information here: *Change Insurance Plan Information* (124).
- **Fee**: The actual fee billed to the patient as entered on the Procedure (303).
- **Fee Schedule**: The fee schedule of the insurance plan listed first in the Family module. If this is a medical procedure code, this fee schedule may not accurately indicate where the fee is pulled from.
- **Substitution Code**: The Ins Subst Code entered for the procedure code. Used for situations like posterior composites, where the insurance company downgrades it to the rate of an amalgam.
- **PPO Fee Schedule**: The fee schedule set for Patient Co-pay Amounts on the Edit Insurance Plan window.
- **Allowed Fee Schedule**: The fee schedule set for Carrier Allowed Amounts on the Edit Insurance Plan window.
- **Allowed Amt**: Frequently, insurance companies do not allow the full fee because they claim it is above UCR for the area. In these cases, enter the allowed fee that should be used for all calculations instead of the Fee. If this is a PPO plan, an allowed amount may already be entered. Click **Edit AllowedAmt** to change the amount in the fee schedule. When entering insurance payments (231), there is also a column for allowed amounts, and these flow into the out of network fee schedule if one is set for the insurance plan (Edit Insurance Plan window, Carrier Allowed Amount). Out-of-network fee schedules can be auto-generated using the Blue Book (918) feature.
- **Patient Copay**: Based on the insurance plan's co-pay fee schedule. Two different uses:
  1. For capitation, this automates calculation of write-off.
  2. For any other insurance, it gets subtracted from the amount that insurance will pay.
- **Deductible**: The amount (usually small, like $50) that the patient must pay each year before insurance kicks in. Usually waived on preventive procedures. As of version 6.7, always subtracted before percentage is calculated.
- **Percentage %**: The percentage that insurance is expected to cover, based on a plan's benefits.
- **Paid By Other Ins**: Adds up all amounts paid by insurance plans that are lower in order. For example, it will never contain an amount if this is primary insurance.
- **Base Estimate**: For situations where the treatment plan needs to show without max or deductible taken into account. This field stores the value to show. Calculated as (Fee or Allowed) - Copay) x (Percentage or Percent Override)
- **Ins Estimate**: Does not take deductibles and annual max into account. This value is the one shown in most places as the estimate. It depends on the order of treatment in the treatment plan. If the claimproc is already attached to a claim, this will not affect the patient balance and you should use Insurance Estimate under Claim Info instead.
- **Write Off Estimate**: Usually only used for PPO plans. This shows as a column in the treatment plan.
- **Estimate Note**: Contains automatically generated notes about annual max that will also show in the treatment plan.

**Claim Info**: Claim information is in the lower right. If the claimproc is still an estimate, the lower portion will not be visible. Once attached to a claim, the lower section can only be edited from within a claim.

- **Deductible**: The actual deductible as reported by the insurance company.
- **Insurance Estimate**: The official amount estimated to be paid. Affects patient balance. Gets copied from Insurance Estimate when claim is created. After that, it can only be changed manually.
- **Insurance Paid**: Once insurance pays, this is the amount actually paid on this procedure. Cannot be edited once the procedure is attached to a check.
- **Write Off**: Amount not covered by insurance that office decides not to charge the patient. This is how Capitation is handled as well as assignment of benefits where provider has agreed not to charge above a set amount.
- **Estimated Patient Portion**: The estimated amount the patient is responsible for after insurance and write-offs (Fee - Insurance Estimate - Write Off).

**Claim Addresses**
In Practice Setup(931) and the Clinic List(1223), there are three options for addresses:

- **Physical treating address**: Usually refers to the physical location where treatment is performed.
- **Billing address**: It cannot be a PO Box. Generally used in e-claims but not paper claims.
- **Pay to address**: Where the insurance payment will go. It can be a PO Box. Does not exist in version 4010 e-claims.

Below is an explanation of the logic that determines which addresses are sent in e-claims and printed claims:

**E-Claims in 5010 Format**

A billing address is required in e-claims and a pay to address is optional.

- **Billing address**: Must be a physical address, not a PO Box.
- **Pay To address**: Sent in addition to the billing address. Can be a PO Box. If left blank, the clearinghouse will consider the treating address the same as the billing address (not sent in 4010 e-claims).
- **Treating address**: Uses physical practice address or, if using Clinics, the physical clinic address.

Open Dental determines an address using the logic below in this order. This table has been ommitted.

**Service Facility address** *(place of service address):*

If a Site is assigned to a procedure on a claim, and a default provider (not a person) and place of service (not office) are set for the site, the site NPI, place of service, and address will be sent in loop 2310C for new 5010 dental e-claims. This is the criteria that must be met:

- At least one procedure on the claim must have a site assigned.
- The site must have a default provider that is marked as Not a Person and has a valid NPI.
- The site must have a valid address, city, state, and zip code.
- The claim place of service is not Office.
- The site provider and claim billing provider cannot match.


Emdeon: If the Pay-To address is sent on an e-claim to Emdeon, then Emdeon will refer to the pay-to address as the billing address on a claim detail printout (since it does not need to be a physical address). It will refer to what is normally considered the billing address as the rendering address since it must be a physical address.

Many carriers began rejecting PO Boxes in the Billing address in 1/1/12. This applies to both 4010 and 5010 formats.

**Printed Claims**

On a printed claim form there is usually an address for the billing provider and the treating provider. The field used for the billing provider address is usually PayToDentistsAddress. The field used as the treating provider is usually TreatingDentistAddress. The field can be verified by looking at the claim form.

Open Dental determines which address populates these fields using the logic below in this order. This table has been ommitted.

**Claimproc Provider** *(for income allocation purposes)*

Some offices want to associate a procedure's insurance income to a general provider, yet retain the treating provider association on the procedure itself. The purpose of this would be to allocate the insurance income to the general provider instead. To do so, you need to be able to change the provider on a claim procedure (claimproc) without changing the provider on the procedure. To make this work, there are specific setup and workflow steps to follow. They are outlined below.
For Example:

- Dr. Jones is the treating provider on an orthodontic procedure for Office A.
- Office A wants the insurance payment for this procedure to be associated to a provider called Ortho, not Dr. Jones.

Warning: In most scenarios, the provider on the Claim Procedures (claimprocs) matches the provider on the associated procedure so that production and income match. In fact, when you change a procedure's provider, by default the matching claim procedure’s provider also changes. It is possible to have mismatched providers, but there are issues you need to be aware of and additional work involved.

- Be extra diligent to prevent accidental provider mismatches. Any time you change the provider on a procedure and want the provider on the claim procedure to match, you will have to change it manually once a procedure is attached to a claim.
- Allowing a mismatch will mean that production on a procedure and the insurance income on that same procedure might not match in reports when ran for specific providers.
- Until claim procedures are attached to a claim, the claim procedure provider will always match the procedure provider. This is by design to prevent accidental provider mismatches.

Instructions

Setup:
1. In Chart Module Preferences (706), turn off the preference Procedure provider overwrites claim procedure provider when attached to claim.
2. For users who are allowed to change the provider on a claim procedure, assign the security permission Claim Procedure Provider Edit When Attached to Claim.

Change the Provider: For this to work, each claim procedure must already be attached to a claim.
1. Treatment plan the procedure and, when ready, mark it complete.
2. Create the claim.
3. From the Claim (208), open the claim procedure (double-click on the procedure).
4. Change the provider and click OK.

Audit Trail: Any time the provider is manually changed on a claim procedure attached to a claim, a log entry will be added to the Audit Trail (1424) for security permission ClaimProcClaimAttachedProvEdit that states the procedure code, a short description of the carrier, the old provider abbreviation, and the new provider abbreviation.

- Note: If you change a procedure's provider and want the provider on the claim procedure (attached to a claim) to match, you must change it manually.
- If the preference Procedure provider overwrites claim procedure provider when attached to claim is not off and you attempt to change the provider, the change will be logged in the audit trail, but the provider on the claim procedure will revert to match the procedure.

Troubleshooting

Claim procedure provider changes are being logged in the audit trail, but the provider is being reset after clicking OK.
Make sure the preference Procedure provider overwrites claim procedure provider when attached to claim is unchecked.

Claim procedure provider changes are not being logged in the audit trail, and the provider is being reset after clicking OK.
Check to make sure the procedure is attached to a claim. Provider changes made before the procedure is attached to a claim will be overwritten.
Find below instructions on how to correct a Claim (208) with errors on the included procedure codes, or attached providers.

**Incorrect Procedure Codes on Claim**

Note: Also follow these steps to correct procedures sent with the wrong treatment area or surface.

If you create a claim that contains incorrect procedure codes and have not sent it:
1. Delete the Claim.
2. Edit or delete the procedures.
3. Recreate claim, then send it.

If you create a claim that contains incorrect procedure codes, send it, and then realize the error or the insurance company denies the claim:
1. First make a Commlog (1654) entry in the account explaining why payment denied.
2. Open the claim and change its status to Waiting to Send.
3. Delete the claim.
4. Edit or delete the procedures.
5. Recreate claim, then send it again.

If an incorrect procedure is submitted to insurance, insurance pays and check is created, then insurance company requests refund:
1. Open the claim.
2. Select the procedure(s), then click Supplemental in the Enter Payment area.
3. Enter a negative insurance payment (refund), then click OK.
4. If a check needs to be written from the practice to the insurance company, write the check, but leave the entry out of the deposit if using a Deposit Slip (516).
5. If the insurance company is subtracting payment from a check for other patients:
   1. Add an Adjustment (203) to the patient's account. The amount should equal the fee charged minus the write-off (e.g. patient portion).
   2. When that bulk check that includes the negative payment is created, the amount will be correct. Deposit as normal.
   3. Do not change the write-off (if any) on incorrect procedure(s).
   4. Leave the date as today's date to preserve the record.
   5. The incorrect procedure should stay on record. Select the procedures, add a note that it was not done, and check the HideGraphics box.

The reason the incorrect procedure needs to stay on record is that paperwork has been submitted to the insurance company and money has exchanged hands. Just removing it makes it harder to explain in the account and makes your reports incorrect. If you must leave the incorrect procedure because of a claim, just add and predate the correct procedure code after you have followed the steps above. Send the claim again as needed.

If you just need to change a procedure code and there is no claim attached, click Change on the Procedure Info (303) window.

**If an incorrect procedure is submitted to insurance, insurance pays and requests a corrected claim:**
1. Commlog or notate on the claim that a corrected claim is necessary.
2. For the incorrect procedures on the original claim, create an adjustment to adjust off the procedure amount. This will zero out the procedure fee.
3. Chart the correct procedures for the original date of service.
4. Create a new claim with the corrected procedures and service dates and send to insurance.
5. We recommend contacting insurance to discuss any potential refunds.

**If an incorrect procedure is submitted to insurance, insurance pays, insurance then requests a corrected claim, and requests a refund for the difference.**
1. Open the original claim.
2. Select the procedure to be refunded and click Supplemental.
3. Enter a negative insurance payment (refund) for the original insurance payment amount, then click OK.
4. For the incorrect procedure, create a negative adjustment to zero out the procedure fee.
5. Chart the correct procedure for the original date of service.
6. Create a new claim with the correct procedure and service date.
7. Click By Procedure to receive the original insurance payment from the original claim.
8. Enter a negative insurance payment (refund) for the amount being refunded to the insurance.

**Incorrect Providers on Claim Procedures**

If the claim is sent to insurance and then you realize the provider on the procedures is incorrect, we recommend calling the insurance carrier to see if this can be fixed over the phone, or if they require a corrected claim.

If you create a claim that has the wrong provider attached to procedures and have not sent it:
1. Delete the claim.
2. Edit the procedures to assign the correct providers.
3. Recreate the claim, then send it.

If you create a claim that has the wrong provider attached to procedures, send it, and then realize the error, or the insurance company denies the claim:
1. If necessary, create a **Commlog** (1654) entry in the affected patient account explaining why the payment was denied.
2. Open the claim and change its status to **Waiting to Send**.
3. Delete the claim.
4. Edit or delete the procedures to use the correct providers.
5. Recreate the claim, then send it.

**If an incorrect provider on a procedure is submitted to insurance, insurance pays and requests a corrected claim:**
1. Commlog or note on the claim that a corrected claim is necessary.
2. For the incorrect procedures on the original claim, create an adjustment to adjust off the procedure amount. This will zero out the procedure fee.
3. Chart the procedures with the correct provider for the original date of service.
4. Create a new claim with the corrected procedures and service dates, and send to insurance.

**If an incorrect provider on a procedure is submitted to insurance, insurance pays, and then is able to correct the provider over the phone:**
1. Double-click on the procedure and change the Provider.
2. Open the claim and double-click on the claim procedure. Edit the Provider on the claim procedure, if needed.

Note: If this is not allowed, go to **Chart Module Preferences** (706) and check the preference **Do not allow different procedure and claim procedure providers when attached to a claim**.

- **Checked:** When you update the Provider on the Edit Procedure window, as long as the claim is marked as **Sent** rather than **Received**, it will update the Provider on the claim procedure as well.
- **Unchecked:** You will be able to change the providers on the Procedures but not on the claim procedure.

**Electronic Attachments**

Except for DentalXChange (see below), attachments to **Claims** (208) and **Preauthorization** (293) must happen outside of Open Dental. Contact your clearinghouse for their preferred attachment method. Below are some known solutions.

**DentalXChange**

**DentalXChange** (656) (ClaimConnect) has their own attachment service directly integrated into Open Dental. See **DentalXChange Attachment** (215) for instructions on adding attachments.
NEA FastAttach
For NEA FastAttach registration and download see: http://www.nea-fast.com/.

For a list of compatible clearinghouses see: https://nea-fast.com/partners/approved-partners/.

NEA can be used with some clearinghouses but you will often have to double enter claim information. After uploading the images, copy/paste the NEA# into the Claim Note field on the Claim (208) (enter the number first e.g. NEA#1234532 other notes go after the number.)

- Note: You must set up the patient in NEA FastAttach in order to receive notifications.
- Attachments are managed at the clearinghouse level if required by the carrier. If you are not notified that an attachment is needed, contact the clearinghouse or carrier. Open Dental is only a place to record attachment information.

Referencing Attachments in Open Dental
To note an attachment to a claim for information purposes, open the claim in Open Dental. You will see an Attachment Tab (214). This tab is for informational purposes only.

Claim Types
In the Account Module (150) toolbar, click the drop down arrow on New Claim.

There are five options when creating a claim: New Claim, Primary, Secondary, Medical, Other. Open Dental assigns a claim type and other options based on the patient's insurance plan situation. The logic is as follows.

Some settings can be manually changed. Users are also not blocked from manually changing the secondary plan on a claim, though this could result in the e-claim sending secondary claim information that is inconsistent with the situations listed in the table. This table has been ommitted.

Claim Type Other
When a patient has three or more dental insurance plans, create an Other type claim.

1. In the **Main Menu** (592), click the New Claim dropdown, Other.

![Create New Claim]

All plans the patient is currently subscribed to will list. To list all insurance plans for the family, including inactive or dropped plans, check **Show plans for family which are not in use by the current patient**.

2. Select the dental insurance plan.
3. Select the patient's relationship to subscriber.
4. Click OK.
5. On the **Claim** (208) verify the claim information and change if necessary.
6. Send or print the claim.

### Receive Claim

In the **Edit Claim** (208) window, at the upper right, is an Enter Payment area.

![Enter Payment]

Click one of the three buttons:

- **As Total**: Enter a total payment amount. This will attach the amount to the claim, but not a specific procedure. On the **Claim Procedure** (221) window enter the Insurance Paid amount and click OK. A line item for Total Payment will show in the Procedures grid. Proceed to Finalizing Insurance Payments.

  Note: This button will be disabled for claims for PPO plans.

- **By Procedure** (recommended): Itemize the payment by procedure. If the plan is a PPO, this is required so write-offs show properly in reports. If you choose this option the list of procedures will show (see below).

- **Supplemental**: Add a new payment for procedures highlighted on a claim that has previously received payment (even if that payment was 0). Will add a new line item for each selected procedure.

The Ins Pay amounts will automatically populate based on insurance estimate calculations. The Status will be **Recd** (received). The Totals at the bottom for deductible and insurance paid should exactly match the EOB.
Receiving a claim means entering payment amounts. Once received, finalize payments by attaching the received claims. See Finalize Insurance Payment(231).

Follow the steps below to receive each claim on an EOB. If an insurance payment includes an additional amount for interest, see Interest on Insurance Payments(236).

If needed, edit insurance payment information.

- **Fee**: Fee billed to patient.
- **Billed to Ins**: Fee billed to insurance.
- **Deduct**: Automatically calculated based on benefit information. Click in the cell to manually edit. To reassign a deductible to a different procedure, highlight the procedure, then click Deductible.
- **Allowed**: Entered amounts will be saved to the out-of-network fee schedule for this insurance plan and used to calculate better estimates for patients with the same carrier. Out-of-network fee schedules can be automatically generated by the Blue Book.
- **Ins Pay**: Automatically calculated based on benefit estimates. Click in the cell to edit.
- **Write-off**: Automatically calculated. Click in the cell to edit or click Write Off in the lower left to create a write-off for all unpaid amounts by procedure (Fee Billed - Ins Pay).
- **Pay Tracking**: Click in cell to select from a list of options (defined in Definitions: Claim Payment Tracking(861)). Useful to track why payments are rejected.
- **Remarks**: Click in the cell to enter remarks for any procedure that has a remark in the EOB.
  - Double click on Date, Prov, Code, Th, Description, Fee Billed or Status to open the Claim Procedures (claimprocs)(221) and edit information.

Click OK to save the procedure payment amounts. The claim status will change to Received.

If entering a single claim, continue to Finalizing Insurance Payments.

If entering a batch payment click OK to close the claim, select the next patient on the EOB, and continue steps 1 - 4 to receive other claims on the EOB. Once all claims are received, continue to Finalizing Insurance Payments.

**Note**: If you enter all the EOB information, including remarks, you can file the EOB and never have to refer to it again. All the information will be in Open Dental and accessible from any computer. If a patient asks why insurance did not pay as expected, you can quickly determine exactly which procedures were not paid and why. If primary insurance is not paid as estimated, secondary insurance estimates do not update.

**Claims with No Payment**
If insurance does not pay on a claim, you must still receive it. Simply enter 0 as the insurance payment amount (As Total or By Procedure). This will mark it as Received so it is no longer considered an outstanding claim.

To scan the EOB associated with the zero payment, finalize the payment as normal (enter 0 as the amount) then scan. See Scan EOB(234).
In the patient account, claims received with no payment show as follows:

<table>
<thead>
<tr>
<th>Date</th>
<th>Name</th>
<th>Doc</th>
<th>Claim</th>
<th>Insurance Provider</th>
<th>Payment Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/02/2013</td>
<td>Zoe</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>DOC</td>
<td>Claim</td>
<td>Pri Claim $310.00</td>
<td>Blue Cross Blue Shield of Oregon</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Albert</td>
<td></td>
<td></td>
<td>Received 06/08/2013</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>NO PAYMENT</td>
</tr>
</tbody>
</table>

Any remaining balance will be due by the patient. Take patient payments as normal.

**Finalize Insurance Payment**

In the Edit Claim(208) window, in the middle, is the Insurance Payments area.

![Insurance Payments Window](image)

Finalizing a claim payment is the important second step after Receiving Claims(229) for an EOB. Entering the payment information is the only way for these payments to show in reports and deposits.

For large batches of claims or larger offices, there is a Batch Insurance Payment(501) feature. The buttons described here are only for small batches or single claims. You can limit where users can finalize payments in Manage Module Preferences(744).

Before finalizing an insurance payment, receive all claims associated with the EOB. Open the Received Claim(229). This window may already be open if you are working off the last claim received. Click either Batch or This Claim Only. If you have been receiving claims, but not finalizing them, then Batch payment amount may be large. See Troubleshooting below.
Enter or change payment information as needed. Some fields will be pre-filled. Some information is optional. Required fields are marked with a * (see Required Fields(71)). If user clicks OK and required fields are incomplete, user will have option to return to the window or proceed.

- **Clinic:** Default to the patient's default clinic (Edit Patient Information(62)). Click the dropdown to change.
- **Payment Type:** The type of payment. Customize options in Definitions: Insurance Payment Types(872).
- **Payment Group:** Typically used to group payments when multiple people are entering payments at once. Customize options in Definitions: Claim Payment Groups(860).
- **Payment Posting Date:** The date of the payment. Defaults to today's date.
- **Check EFT Issue Date:** Optional. The date the EFT payment was issued.
- **Amount:** The total amount of the EOB. If the amount autopopulated does not match the amount on the EOB, enter the EOB amount manually and refer to Troubleshooting below.
- **Check #:** Useful for reporting. For EFT, use this field to enter the EFT number.
- **Bank-Branch:** Useful for reporting.
- **Carrier Name:** Auto populated with the claims insurance carrier.
- **Virtual Credit Cards:** If payment is via a virtual credit card and XCharge (OpenEdge)(173), PayConnect Window(168), or PaySimple(186) is enabled, you will see the XCharge, PayConnect, or PaySimple buttons. Click a button to process the payment. When the transaction is complete, the Edit Insurance Payment window will still be open and transaction details will show in the Note.

Note: For PaySimple users, the Carrier Name will be sent to PaySimple when processing a credit card transaction.
• **Auto Deposit**: Only visible if *Insurance Payments: Show Auto Deposit* is enabled in Manage Module Preferences.
  - Date: Date used on the deposit.
  - Amount: Amount of deposit. Will match check amount.
  - Batch #: Optional. Used to track deposits.
  - Auto Deposit Account: Select the deposit account. Customize options in Definitions: Auto Deposit Account(846).

Click OK to save and proceed to the Insurance Payment (EOB) window

Note: If you click **Cancel** instead, transaction details are not saved.

Verify that all attached claims apply to this payment.

• **Payment Details**: Information entered on the previous window. Click **Edit** to change.

• **Attached to this Payment**: All received claims not attached to a payment. By default, the list is sorted in the order claims were entered. To change the sort order, use the Up/Down arrows. To open a claim, double click on the row. To remove a claim, highlight it, then click **Detach**.
  
  Note: Once detached, claims cannot be reattached without deleting the payment and starting over.

**View ERA**: Click to view associated ERA. See EOB Claim Details(573).

**Scan EOB**: If desired, scan the EOB. Click in the lower left of the Insurance Payment (EOB) window. See Scan EOB(234).

When the correct claims are attached to the payment and the Total Payments equals the Payment Details Amount, click OK.

If there are any secondary claims, a new window will show listing the claims. See Secondary Insurance(132).
The insurance payment will list in the Account module. If you reopen any claim attached to the payment, the Insurance Payments area on the Edit Claim window will show the payment.

**Delete:** If you delete an insurance payment, received claims will remain unattached until a new payment is created. Payment splits are not affected.

**Troubleshooting**

**When entering a batch insurance payment, the default amount is too big and does not match the EOB amount.**

This occurs when claims have been received, but not finalized. All received claims not finalized are automatically included in the total amount calculation, and you will see the claims listed in the Attached to this Payment grid.

1. For this claim, manually change the amount, manually detach claims not tied to this payment, then save the payment.
2. For all received claims that are not tied to a payment (detached), reopen the claim, then finalize.

If you always receive the claim(s), then finalize, the amounts and claims will always be accurate and data entry will be reduced.

Insurance payments that haven't been finalized are indicated with a note:

<table>
<thead>
<tr>
<th>Date</th>
<th>Name</th>
<th>Type</th>
<th>Payment</th>
<th>Amount</th>
<th>Payment Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>06/08/2013</td>
<td>Zoe</td>
<td>DOC</td>
<td>InsPay</td>
<td>310.00</td>
<td>0.00</td>
</tr>
</tbody>
</table>

**A procedure has a write-off, yet we received zero payment.** When finalizing the payment, we changed the payment date to match when we received it. Now the procedure with the write-off and zero payment incorrectly shows the date we entered the payment instead of the date we received it. There are two entries for the payment in the Patient Account since they have different dates.

You must manually open the procedure on the claim and change the payment date to the receive date. This will merge the two payment entries into one since they will have the same date.

**What if I cannot receive all of the claims that make up my bulk check/payment and I need to leave for the day?**

Do not finalize the payment until you finish receiving all the claims. This way all claim payments will have the same payment date.

**I have a bulk payment but the carrier is taking back money from a previous claim. How do I enter the claim?**

See [Insurance Refunds](238).

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**Scan EOB**

The Insurance Payment (EOB) window is described at the bottom of both [Finalize Insurance Payment](231) and [Batch Insurance Payment](501). In the lower left corner of that window, there is an area indicating if the EOB is already scanned.

If the EOB is not scanned (No), click Scan EOB to scan the EOB. If EOB is already scanned (Yes), click View to view the EOB.

We recommend entering all EOB information (including remarks) with payment details so you can refer to and access it when needed. If a patient asks why insurance did not pay as expected, you can quickly determine exactly which procedures were not paid and why.
**Printer:** Opens the Select Printer window so you can print the selected image. The image will automatically resize to fit the printed page.

**X:** Delete the selected image.

**Scan Document:** Use the flatbed scanner of your attached device to scan a single page of the EOB.

**Scan Multi-Page Document:** If you have an automatic document feeder (ADF), scan multiple pages at once.

**Import:** Import an existing EOB file from your computer or network.

**Export:** Export the selected EOB file to another location on your computer or network. Only image files can be exported (e.g. JPG, GIF, BMP). PDF files cannot.

**Copy:** Copy the selected item to the clipboard.

**Paste:** Paste an item from the clipboard.

**Close:** Close the EOB window.

**Magnifying Glass + and -:** Zoom in and out in 50% increments, or click 100 to view the EOB at 100%.

Scanned and imported EOBs are stored in the **OpenDentImages\EOBs** folder.
Interest on Insurance Payments
When Receiving a Claim (229), if there is an interest charge, there are three options for entering it.

**Option 1:** If this is a PPO plan and the write-off amount is greater than the interest payment, follow these steps. This method keeps your account accurate, but does not track interest amounts.
1. For a specific patient, open the claim, then click on a procedure to open the Claim Procedures (claimprocs) (221).
2. Add the interest payment amount (what the insurance paid extra) to the Allowed Amt.
3. Reduce the write-off amount by the interest payment amount.
4. Enter the insurance payment, including the interest amount.
5. Click OK to save.

**Option 2:** This method adds a supplemental payment to the claim and an adjustment to the patient account.
1. For a specific patient, open the sent and received claim. A finalized insurance payment should already be created for the initial payment amount.
2. Highlight a procedure, then click Supplemental.
3. Enter the amount of the interest payment, enter a note that it is an interest payment, then click OK.
4. Click Finalize Payment, enter the payment information, then click OK. We recommend entering a note that it is an interest payment.
5. If Payment and Total Payment amounts match, click OK. At least two finalized payments will show in the Insurance Payments area of the Edit Claim window: one for the insurance payment amount, one for the interest amount.
6. The patient balance will now reflect the interest amount. Add an adjustment to subtract the interest amount from the patient's account. We recommend you create an Interest adjustment type in Definitions: Adj Types (841).

To track interest amounts, run an Daily Adjustments Report (1292).

**Option 3:** This method requires more steps, but allows you to track interest amounts per insurance company.
1. Create a fake patient named for the insurance company. e.g. Interest.
2. In the fake patient's Family Module (59), add the patient's insurance plan.
3. Create a N code procedure called interest or service charge.
4. Add the N code procedure to the fake patient's Chart Module (298) and verify the correct provider is assigned (who should receive the charge or payment). Set the procedure complete.
5. Go to the Account Module (150). The N code procedure will have a zero fee. Highlight the procedure, then click New Claim. Change the status to Sent, then click OK to create the claim.
6. Receive Claim (229): Reopen the claim and enter a By Procedure Claim Payment (231). Indicate the amount charged or credited to you by insurance. For charges (e.g. service charges), enter a negative number.
7. Enter the payment: Click Create Insurance Payment, then click OK. All patients on that check should be in the Attached to this Payment list, and the Payment Detail Amount should match the Total Payments amount. Click OK.

The fake patient should have an account credit or balance. Do not make an adjustment; leave the balance as is.

To keep track of insurance interest, make an adjustment at the end of the year (Adjustment (203)). Then, create a new fake patient for any new insurance to keep the information separate.

**Split Claim**
In the Edit Claim (208) window, at the upper right, click Split Claim.
Splitting claims is useful if insurance only paid on some of the procedures in an Insurance Claim Payment, and you are still waiting on payment for the other procedures.

Then you can receive and enter payment for one claim, and the unpaid claim will remain outstanding.

Typical reasons to split a claim:

**Scenario 1:** Insurance rejects a claim due to missing information on one procedure. Split the rejected procedure into a new claim, then resubmit the original claim. Once information is updated for the rejected procedure, send with the split claim.

**Scenario 2:** Insurance decides to split one procedure from the claim because it will take longer to adjudicate. The EOB or ERA will indicate that the claim has been split. Manually split the procedure from the original claim. Since the procedure has already been submitted to insurance, it does not need to be resent.

1. On the claim, highlight the procedures that are NOT included in the current payment.
2. Click Split Claim. The procedures you received payment for should list under Procedures. The claims not included with the payment will be in a new claim.
3. Receive the claim, then finalize the payment. See Receive Claim(229) and Finalize Insurance Payment(231).

In the patient account there will be two claims: one received with a payment and one outstanding.

Any claim statuses from the original claim will be copied to the split claim. See Edit Claim - Status History Tab(219).

When you receive payment for the outstanding claim, receive the claim, then finalize the payment.

**Troubleshooting**

*Message: Claim identifier already in use for another claim.*

Split claims have a unique claim identifier. When notification of a split claim is received on an ERA (scenario 2 above) note that the claim identifier for both original and split claim on the ERA will be the same, even though the identifiers in Open Dental will be different. The difference will not affect matching of ERAs to claims because other criteria is used.

---

**Supplemental Insurance Payments**

In the Claim(208) Edit window, at the upper right, is a Supplemental button.

Supplemental claim payments are payments for procedures that have already been marked received. This can include additional payments, or negative amounts (e.g. insurance reduces a payment). Like any insurance payment, you must receive it, then finalize the payment by attaching it to the claim.
Highlight the procedure the supplemental payment applies to.

Click **Supplemental** in the upper right corner.

Enter the payment amount in the Ins Pay column, then click **OK**.

On the Edit Claim window, click **This Claim Only** if finalizing a single claim, or **Batch** if finalizing for a batch payment.

Enter the amount and verify the attached claim(s). See Finalize Insurance Payment(231).

Once created, supplemental payments will display as an additional line item in the grid of procedures with the Status of **Supp**.

<table>
<thead>
<tr>
<th>#</th>
<th>Date</th>
<th>Prov</th>
<th>Code</th>
<th>Tth</th>
<th>Description</th>
<th>Fee Billed</th>
<th>Deduct</th>
<th>Ins Est</th>
<th>Ins Pay</th>
<th>Write Off</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>01/21/2015</td>
<td>Miller</td>
<td>D0150</td>
<td></td>
<td>comprehensive oral evaluation - new or established patient</td>
<td>68.00</td>
<td>0.00</td>
<td>68.00</td>
<td>58.00</td>
<td>0.00</td>
<td>Recd X</td>
</tr>
<tr>
<td>1</td>
<td>01/21/2015</td>
<td>Miller</td>
<td>D0150</td>
<td></td>
<td>comprehensive oral evaluation - new or established patient</td>
<td>0.00</td>
<td>0.00</td>
<td>10.00</td>
<td>0.00</td>
<td>0.00</td>
<td>Supp X</td>
</tr>
</tbody>
</table>

Note: Negative write-off amounts can be entered in a supplemental payment to account for adjustments to write-offs already entered, as long as the net write-off is 0 or greater. This is useful when the write-off amount changes and you do not want to or cannot change the original write-off amount (e.g. doing so would change historical reports).

**Automatic Supplemental Payments**

Supplemental payments can be automatically created by the Income Transfer Manager(195) if a claim was originally received As Total, rather than By Procedure.

Automatic supplemental claim transfers cannot be edited but may be deleted. If a transfer entry is deleted, all other transfer entries on the claim are deleted as well.

Additionally, if a claim with a supplemental transfer is edited, all the supplemental transfer entries will be deleted. This includes editing or deleting a received claim procedure from the Claim(208) Edit window and the Procedure(303) Info window, and entering additional insurance payments to the claim.

Open the Income Transfer Manager and click OK to re-transfer any remaining unallocated claim payments.

**Insurance Refunds**

If insurance overpays on a Claim(208), they will either request a refund check, or they will allocate the overpayment to another patient.

**Refund via check**

1. In the Account Module(150), double-click on the claim.
2. Highlight the involved procedures, then click **Supplemental**(237) at the upper right.
3. Enter the refund amount as a negative amount for Ins Pay (e.g. -10), then click OK.
4. In the Claim(208), click **This Claim Only**.
5. Enter any needed check information and enter the payment amount as a negative (e.g. -10).
6. Complete the rest of the payment as normal. See Finalize Insurance Payment(231).

- Note: You may wish to create a new Payment Type(879) for Insurance Refund checks to avoid incorrect totals if using Deposit Slips(516).
- If you are refunding insurance due to eligibilty, you may need to add a supplemental payment to adjust off the write-offs as well.
This will correct the patient account balance making the patient responsible for the previous overpayment. If you do not want the patient to be responsible for the amount, enter a negative adjustment to subtract the amount from the account balance (Adjustment(203)).

Deduct from a different patient
1. Go into patient A’s account (the patient the refund is being allocated to).
2. Double click on the claim and receive using the information provided on the EOB. See Receive Claim(229).
3. Go into patient B’s account (the patient who was originally given the overpayment) and enter a negative payment, as described above.
4. Once all claims on the EOB are received, finalize the payment as usual. See Finalize Insurance Payment(231).

Payment Plan
A Payment Plan is essentially a loan to a patient.

In the Account Module(150), the Payment Plans grid lists all payment plans associated with the family.

Note:
The grid can also include simpler Installment Plans(260) and Insurance Payment Plans(258).

In the toolbar, click Payment Plan, Patient Payment Plan, or double-click an existing plan to edit.
To set when payment plan payments will be due, see Manage Module Preferences (744), Days in advance to bill payment plans amounts due.

See Dynamic Payment Plan to create an open ended repayment agreement.

Related Links:
- Payment to a Payment Plan (246)
- Payment Plan Examples (249)
- Payment Plans Report (1321)
- Payment Plan Q and A (255)

Category: Assign a category to this payment plan (e.g. Ortho, Implant). Useful to distinguish one payment plan from another when families have many plans. Customize the category options in Definitions: Payment Plan Categories (878).

Patient: The person who was treated. Click Go To to switch to their account. Patients can have multiple payment plans, and each plan can have a different guarantor.

Guarantor: The person who will make the payments. It does not have to be in the same family as the patient. It also can differ from the account's guarantor. Click Change to select. Click Go To to switch to their account.

Provider: Defaults to the patient's primary provider. Click the dropdown or [...] to change. If using clinics and providers are restricted to clinics, only providers available for the selected clinic are options.

Clinic: If using clinics, defaults to the patient's clinic. Click the dropdown to change.

Insurance Plan (insurance payment plans only): The insurance plan this payment plan is for. To edit, click Change, select the plan, then OK. Insurance payment plans can be used to track installment payments for a single claim.
**Date of Agreement:** Defaults to today’s date.

Terms that affect the Amortization schedule.
- **Total Amount:** The total amount of the payment plan, not including interest. It defaults to the patient’s current balance.
- **Date of First Payment:** Defaults to one month from today’s date so amortization calculations will be accurate. If you change the date, there may be minor discrepancies in interest charged. If the first payment is today, enter it as the down payment and set the Date of First Payment as one month in the future.
- **Down Payment:** The amount of the down payment.
- **APR:** The percentage of interest to charge.
- **Number of Payments/Payment Amount:** The amortization schedule can be based on a total number of payments or a specific payment amount. Enter only one.
- **More Options:** Select how often payments will be due based on the Date of First Payment. The default frequency is Monthly, however other options include every other week, first day of a month, or quarterly.

**Create Schedule:** Create the amortization schedule based on the terms. A description of the terms will show in the Note field.

**Recalculate:** Recalculate payments and interest (optional) when a patient prepays, pays on principal, or overpays. See Payment Plan Recalculate(253).

Note: Added adjustments will not be recalculated. Manually edit any payment plan adjustments in the patient account, amortization schedule, and in the Payment Plan Procedures and Credits window.

**View Tx Credits:** Click to attach procedures in Payment Plan Procedures and Credits(256). Credits will be created for each procedure that determine how much will be subtracted from the patient’s balance.

If a procedure’s provider is different than the payment plan’s provider, Open Dental will warn you. If you proceed (click Yes) the payment plan provider will be assigned to the payplan charges, however, future payment splits will be allocated to the procedure provider when the Enforce Valid Paysplits Account Module Preferences(693) is set to something other than Don’t Enforce. Income transfers may also be incorrect. See Payment Plan Q and A(255).

Once the schedule is created, these calculations are automatic:
- **Total Cost of Loan:** Total Amount plus interest and any added charges.
- **Accumulated Due:** The total amount that has been due up to the current date.
- **Paid so far:** The total amount that has been paid towards the payment plan to date.
- **Principal paid so far:** The total that has been paid towards the principal to date.
• **Tx Completed Amt**: The total fee amount for completed procedures and credits that are attached to the payment plan. This will determine the credit amount applied to the account. Once treatment planned procedures are completed, they are automatically applied to the Tx Completed Amt and credited to the patient's balance.

• **Total Tx Amt**: The total fee amount for all procedures (treatment planned and completed) that are attached to the payment plan. If the Total Amount does not match the Total Tx Amt, you will be prompted to change the Total Amount to match. This is optional.

**Amortization Schedule**: The amortization schedule is generated based on the terms. Principal and interest are calculated automatically. Due dates are based on the Date of First Payment and the frequency selected for More Options.

- A horizontal bold line indicates today's date and separates past items from future items.
- The amount currently due is bold.
- Payments attached to this payment plan show as credits and affect the running balance. If extra payments show here, but shouldn't, uncheck the Attached to Payment Plan box on the Payment window for each payment.
- **Click Clear Schedule** to erase the current amortization schedule, including adjustments (e.g. if you are unhappy with it and want to recalculate with different terms).
- **Exclude past activity**: When checked, only future dated line items show in the Amortization Schedule and past activity is hidden. When unchecked, all activity shows. Totals are not affected by this setting. To set the default setting for the checkbox, see Account Module Preferences, Payment Plans exclude past activity by default.

**Interest**: Open Dental automatically calculates interest (APR) using the following method. Most online calculators use the same method, but some may differ (e.g. assume down payment is first month's payment).

1. Subtract the down payment from the payment plan balance.
2. Calculates the number of payments, or the payment amount, based on the new balance (balance minus down payment).

Double click individual charges to edit, or click Add to add a new charge. This is not recommended. If you manually edit or add charges, you must manually calculate any interest changes.

**Add Adjustment**: Enter a negative payment plan adjustment to discount a portion of the payment plan balance (e.g. for a courtesy discount).
Adaptations automatically reduce the Terms Total Amount, apply credits to future due amounts, and reduce the Total Tx Amt (via an adjustment in the Payment Plan and Procedures and Credits window). To also include an adjustment in the Patient Account ledger with today’s date, check **Also make line item in Account Module** (not recommended when using Account Module Preference Pay Plan Charge Logic, Do Not Age (Legacy)).

- The amount of the adjustment cannot be more than the remaining payment plan balance due.
- Enter payments to the payment plan before adding payment plan adjustments; otherwise, the suggested paysplits to payment plan charges may not be available.
- To edit or delete a payment plan adjustment, change the line item in the patient account, the Amortization Schedule, and in the Payment Plan Procedures and Credits window.
- Set the adjustment type used, in Account Module Preferences, Pay/Adj tab.

**Note**: When you create the schedule, a detailed note of the terms shows for future reference. Other notes can be added as needed.

**Delete**: Delete this payment plan. You cannot delete payment plans with payments attached.

**Close Plan**: Close Payment Plans (248) that are no longer being paid on. Any remaining charges will become due immediately.

**Print / Sign & Print / View & Print**: The button label will change depending on options that have been set up for printing and signing payment plan terms. See Sign and Print Payment Plan (243).

### Sign and Print Payment Plan
In a Payment Plan (239), at the bottom, is a Sign & Print button.

Terms for Payment Plans can be electronically signed by the patient and printed. Electronic Signatures (306) are only an option when using a custom printed payment plan layout that has a signature box. See Payment Plan Layout (1174).

**Electronically Sign Terms**
When using a custom Payment Plan Sheet that has a signature box, the terms can be electronically signed before printing or saving. Pay Plans use Sheets must be checked in the Account Module Preferences (693).

After the initial setup is complete, a Sign & Print button will appear below the amortization schedule on the Payment Plan (239).

Click Sign & Print to preview the payment plan terms and electronically sign.
Sign the terms.

Click a button to save, print, email the terms.

- **Create PDF:** Preview and save a PDF copy of the terms. The PDF is only viewable by clicking View & Print in the Payment Plan (239).
- **Print/Email:** Print and/or email the terms to the guarantor and save a PDF copy in the Images module.
• **Save**: Save a PDF copy in the Images module.
• **Cancel**: Close the window without saving.

PDF versions of saved payment plans are saved in the Images module in the folder designated for payment plans ([Definitions: Image Categories](869)).

Invalidated signatures: If terms on a signed payment plan are changed or the layout of the sheet changes, the signature will invalidate. To re-sign:
1. Click View & Print.
2. Click Unlock to unlock the sheet (Sheet Edit security [Permission](1118) required).
3. Click X to clear the invalidated signature.
4. Sign the terms.

**Print Terms (without signing)**
If using the classic payment plan layout, or an electronic signature does not exist on the custom payment plan sheet, a Print button shows below the amortization schedule. Click Print to preview the terms.
Payment to a Payment Plan

If a Payment Plan (239) exists, then any Payment (153) will be automatically attached to the Payment Plan. If multiple Payment Plans exist, you will be prompted to select one.
Usually patient payments to payment plans are entered from the account of the person making the payment, typically the guarantor. However in certain situations it can be a different account, for example when one parent is the guarantor and the other parent makes the payment.

Follow the typical steps for entering a payment or Credit Card Payment(166). The payment will be automatically attached to the existing payment plan. If a payment needs to be later attached to a payment plan, then double click on the Paysplit(161), and check the box at the very bottom of that window. If more than one payment plan is available to pick from, then you will be able to select one.

Depending on the method of allocation your office uses, Open Dental may automatically suggest paysplits allocated to the payment plan charges based on first in/first out logic (FIFO).

- Note: Open Dental will automatically generate paysplits for payment plan interest. We do not recommend editing these splits because it may cause future splits to allocate to the incorrect provider.
- If discounting future amounts due, enter payments before adding payment plan adjustments; otherwise, the suggested paysplits to payment plan charges may not be available.

Payment plan payments will always show in the payment plan's amortization schedule. Double click the plan to view.

If your office's Pay Plan Logic in Account Module Preferences(693) is Aged Debits and Credits, payment plan payments will also show in the ledger of the patient or the payment plan guarantor (if the guarantor is not in the same family).

**Early Payments to a Payment Plan**

In cases where a patient would like to make a payment towards a Payment Plan before an amount is due the above process will not work. There are two options for how to handle this scenario.

- The first option is to modify the next payment date to the current date.
  1. From the Account Module(150), double-click on the Payment Plan where you would like the early payment applied.
  2. In the Amortization Schedule, find the line item for the next payment due date and double-click to edit.
  3. Change the Date entry to the current date and click OK to save.
  4. You will now be able to take the payment as above. It will be automatically attached to the payment plan.
The second option is to take the payment as unearned income.

1. Click payment and create splits for an Unearned / Prepayment.
2. Set a reminder for the next due date from the payment plan.
3. On that date, click the payment dropdown and select Allocate Unearned.
4. Verify the amount and payment splits that have been created are accurate to match the intended payment plan. Click OK to complete process.

Close Payment Plan
In a Payment Plan, at the lower left, click Close Plan.

When a patient is no longer paying on a Patient Payment Plan, you can close it so it no longer shows in the Payment Plan grid. There will still be record of the payment plan and it can be reopened if needed. We recommend closing payment plans no longer being paid on, even if there are charges still due.

Closing out a plan does the following:
- Makes any unpaid principal amounts (e.g. for future payments) due immediately. Closeout charges always post to the patient of the payment plan.
- Accounts for discrepancies between the total amount paid and the credit for procedures attached to the plan.
- Removes interest charges for future-dated debits. It does not affect historical debits.
- If using Age Credits and Debits Pay Plan Logic (Account Module Preferences), closed payment plans will be hidden in the Payment Plan grid. Otherwise payment plans are only hidden if they are paid in full (payment plan balance = 0).

When pay plan logic is Age Credits and Debits, the payment plan will no longer show in the Payment Plans grid and any outstanding principal amounts will be added as a PayPlan Debit line item in the patient account ledger (with a note of Close Out Charge).

When pay plan logic is Age Credits Only or Do Not Age, any balances remaining will be due now. Once the payment plan balance = 0, the plan will no longer show in the grid.

Automatically Close Out Payment Plans
During the update to version 16.2, all existing payment plans that have a zero balance and no future charges are automatically closed.

There is also a tool to automatically close all payment plans with a zero balance and no future charges. This is useful if you have payment plans showing in the Payment Plan Report that have zero balance, no future charges, but are not closed.

In the Main Menu, click Tools, Misc Tools, Auto-Close Payment Plans.
Click OK to close all plans that meet the criteria.

Note: Automatic closing of plans does not work for Oracle users. Instead manually close plans.

**View or Reopen Closed Payment Plans**

Payment plans that have been closed are still available to view or to reopen if needed. Only open payment plans can be edited; changing historical information is not recommended.

To show closed payment plans in the Payment Plan grid:
1. In the Account Module, click the Show tab.
2. Check the box for **Show Completed Pay Plans**. This will affect all workstations.

All closed plans for the patient will list in the Payment Plan grid in a light text color.

To reopen a closed payment plan:
1. Double click the closed plan to open the Payment Plan window.
2. In the lower right, click Reopen.

Only past activity shows in the amortization schedule. To reinstate the payment plan, you will need to create a new amortization schedule.

**Payment Plan Examples**

Below is guidance on how to set up a **Payment Plan** (239) for certain scenarios. All examples assume that procedure fees and insurance estimates are set up correctly.

See [Dynamic Payment Plan](#) to create an open ended repayment agreement.

**Patient Payment plan for treatment that is already completed:** Create a payment plan and attach the completed procedures as credits. The Total Amount, Tx Completed Amt, and Total Tx Amt will match.
Patient Payment plan for procedures that are treatment planned, but not complete yet: Create a payment plan and attach the treatment planned procedures. The Total Amount and Total Tx Amt will match. The Tx Completed Amt will initially be 0, but as the procedures are marked complete, the amount will automatically update. Payment plan credits in the account ledger will also be added as procedures are completed, thus offsetting the procedure charges.
**Patient Payment plan for completed procedures and treatment planned procedures:** Create a payment plan and attach the completed and treatment planned procedures. The Total Amount and Total Tx Amt will match. The Tx Completed Amt will initially equal the value of all completed procedures. As the treatment planned procedures are marked complete, the amount will automatically update. Payment plan credits in the account ledger will also be added as procedures are completed, thus offsetting the procedure charges.
Patient Payment plan where you know the total payment plan amount, but do not want to attach procedure credits: Create a payment plan and attach an unattached credit (Click Tx Credits, click Clear to de-select all procedures, enter the payment plan amount, click Add). The unattached credit amount will be considered a completed amount (Tx Completed Amt) and match the Total Tx Amt and Total Amount.
Payment Plan Recalculate

If a patient makes a payment for a Payment Plan that is intended as an early payment (before the payment plan amount is due) or a payment to principal, future payments and interest can be recalculated.

In a Payment Plan (239), under Terms, click Recalculate.

Note: Added adjustments will not be recalculated. Manually edit any payment plan adjustments in the patient account, amortization schedule, and in the Payment Plan Procedures and Credits window.
Enter the payment. See Payment to a Payment Plan (246).

In the Account Module (150), double-click the original payment plan. The payment will show as an line item in the amortization schedule.

Under Terms, click Recalculate.

Select how payment should be allocated.
- **Prepay**: The amount will be applied to future amounts due (e.g. towards the next due payment).
- **Pay on Principal**: The amount will be subtracted from the total balance, then remaining charges will be recalculated.

To also recalculate interest, check the Recalculate Interest box.

Click OK to recalculate payments.

Late Payments: Interest can also be recalculated for early or late payments. It does not matter which allocation method you choose.
- If you do recalculate interest, the accrued interest is added to outstanding interest amounts then recalculated.
- If you do not recalculate interest, the accrued interest is added to the next payment; the outstanding amounts remain the same.

**Example**
Patient has a $1000 payment plan with a 5% interest rate and 4 payments. Patient pays $252.61 before payment #2 is due, making the payment plan balance - 252.61.

<table>
<thead>
<tr>
<th>Date</th>
<th>Provider</th>
<th>Description</th>
<th>Principal</th>
<th>Interest</th>
<th>Due</th>
<th>Payment</th>
<th>Balance</th>
</tr>
</thead>
<tbody>
<tr>
<td>06/15/2016</td>
<td>DOC Sparks</td>
<td>#1</td>
<td>248.44</td>
<td>4.17</td>
<td>252.61</td>
<td></td>
<td>252.61</td>
</tr>
<tr>
<td>06/15/2016</td>
<td>DOC Sparks</td>
<td>Check $252.61</td>
<td></td>
<td></td>
<td></td>
<td>252.61</td>
<td>0.00</td>
</tr>
<tr>
<td>06/30/2016</td>
<td>DOC Sparks</td>
<td>Check $252.61</td>
<td></td>
<td></td>
<td></td>
<td>252.61</td>
<td>-252.61</td>
</tr>
<tr>
<td>07/15/2016</td>
<td>DOC Sparks</td>
<td>#2</td>
<td>249.48</td>
<td>3.13</td>
<td>252.61</td>
<td></td>
<td>0.00</td>
</tr>
<tr>
<td>08/15/2016</td>
<td>DOC Sparks</td>
<td>#3</td>
<td>250.52</td>
<td>2.09</td>
<td>252.61</td>
<td></td>
<td>252.61</td>
</tr>
<tr>
<td>09/15/2016</td>
<td>DOC Sparks</td>
<td>#4</td>
<td>251.56</td>
<td>1.05</td>
<td>252.61</td>
<td></td>
<td>505.22</td>
</tr>
</tbody>
</table>

If you recalculate as a prepay (interest also recalculated), the payment will be applied to the next payment (payment #2).

<table>
<thead>
<tr>
<th>Date</th>
<th>Provider</th>
<th>Description</th>
<th>Principal</th>
<th>Interest</th>
<th>Due</th>
<th>Payment</th>
<th>Balance</th>
</tr>
</thead>
<tbody>
<tr>
<td>06/15/2016</td>
<td>DOC Sparks</td>
<td>#1</td>
<td>248.44</td>
<td>4.17</td>
<td>252.61</td>
<td></td>
<td>252.61</td>
</tr>
<tr>
<td>06/15/2016</td>
<td>DOC Sparks</td>
<td>Check $252.61</td>
<td></td>
<td></td>
<td></td>
<td>252.61</td>
<td>0.00</td>
</tr>
<tr>
<td>06/30/2016</td>
<td>DOC Sparks</td>
<td>Check $252.61</td>
<td></td>
<td></td>
<td></td>
<td>252.61</td>
<td>-252.61</td>
</tr>
<tr>
<td>06/30/2016</td>
<td>DOC Sparks</td>
<td>Recalculated based on prepayment</td>
<td>252.61</td>
<td>0.00</td>
<td>252.61</td>
<td></td>
<td>0.00</td>
</tr>
<tr>
<td>07/15/2016</td>
<td>DOC Sparks</td>
<td>#2</td>
<td>-3.12</td>
<td>2.08</td>
<td>-1.04</td>
<td>-1.04</td>
<td>-1.04</td>
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<tr>
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<td>DOC Sparks</td>
<td>#3</td>
<td>250.53</td>
<td>2.09</td>
<td>252.62</td>
<td></td>
<td>251.58</td>
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<tr>
<td>09/15/2016</td>
<td>DOC Sparks</td>
<td>#4</td>
<td>251.54</td>
<td>1.05</td>
<td>252.59</td>
<td></td>
<td>504.17</td>
</tr>
</tbody>
</table>

If you recalculate as pay on principal (interest also recalculated), the payment will first subtract from the total balance.
Then the remaining payments will be recalculated based on the new balance (new balance / remaining payments = new due amounts).

<table>
<thead>
<tr>
<th>Date</th>
<th>Provider</th>
<th>Description</th>
<th>Principal</th>
<th>Interest</th>
<th>Due</th>
<th>Payment</th>
<th>Balance</th>
</tr>
</thead>
<tbody>
<tr>
<td>06/15/2016</td>
<td>DOC Sparks</td>
<td>#1</td>
<td>248.44</td>
<td>4.17</td>
<td>252.61</td>
<td>252.61</td>
<td>252.61</td>
</tr>
<tr>
<td>06/15/2016</td>
<td>DOC Sparks</td>
<td>Check $252.61</td>
<td></td>
<td></td>
<td>252.61</td>
<td></td>
<td>0.00</td>
</tr>
<tr>
<td>06/30/2016</td>
<td>DOC Sparks</td>
<td>Check $252.61</td>
<td></td>
<td></td>
<td>252.61</td>
<td></td>
<td>-252.61</td>
</tr>
<tr>
<td>06/30/2016</td>
<td>DOC Sparks</td>
<td>Recalculated based on pay on principal</td>
<td>252.61</td>
<td>0.00</td>
<td>252.61</td>
<td></td>
<td>0.00</td>
</tr>
<tr>
<td>07/15/2016</td>
<td>DOC Sparks</td>
<td>#2</td>
<td>165.63</td>
<td>2.08</td>
<td>167.71</td>
<td></td>
<td>167.71</td>
</tr>
<tr>
<td>08/15/2016</td>
<td>DOC Sparks</td>
<td>#3</td>
<td>166.32</td>
<td>1.39</td>
<td>167.71</td>
<td></td>
<td>335.42</td>
</tr>
<tr>
<td>09/15/2016</td>
<td>DOC Sparks</td>
<td>#4</td>
<td>167.00</td>
<td>0.70</td>
<td>167.70</td>
<td></td>
<td>503.12</td>
</tr>
</tbody>
</table>

**Troubleshooting**

A patient has not paid their balance for more than one month and you want to recalculate interest. When you recalculate, it will only recalculate the interest for the balance at time you recalculate; it will not take into account more than one month.

**Payment Plan Q and A**

Below are some questions and answers about Patient Payment Plans (239).

**Pay Plan Logic Q and A**

I am considering transitioning to Age Credits and Debits logic. What do I need to know?

When you first transition, patient account balances will change:
- The account balance for any patient with a patient payment plan will change by the payment plan amount currently due.
- The Family Aging amounts will include patient payment plan charges currently due.
- The total A/R in the Aging of Accounts Receivable (A/R) Report (1308) will change.

How can I see the difference between Do Not Age logic and Age Credits and Debits logic in the Aging of A/R Report amounts?

1. With Do Not Age selected:
   - Run the Aging of A/R report (Check Include Negative Balances).
   - Run the Payment Plan Report (1321). Select Patient as the Payment Plan Type. Uncheck Hide Completed Payment Plans and Limit to Plans Created in Date Range. The Due Now column will indicate the total payment plan amount due.

2. With Age Credits and Debits selected, run the Aging of A/R report again (Check Include Negative Balances).

The Total column from the report in step 1 (traditional) + the Due Now amount from the Payment Plan report will equal the Total column from report in step 2 (Age Credits and Debits).

**How do payment plans affect billing?**

Payment plan amounts due are included when you run Batch Billing (504). The due date is based on a setting in Manage Module Preferences (744) for Days in advance to bill payment plans amounts due. The Pay Plan Logic determines whether or not the payment plan amount due is added to the total amount due on the statement.

**Payment Plan Adjustments**

I have already set up a payment plan for a patient, but now want to add an adjustment (e.g. for a courtesy discount). How do I edit the payment plan to reflect the discount?
To add an adjustment to a payment plan:
1. Apply any payment plan payments.
2. Open the patient’s payment plan.
3. Click Add Adjustments (203).
   o Enter the adjustment amount.
   o Check Also make a line item in the account, to create an adjustment on the Patient Account ledger (not recommended if the Account Module Preferences (693) Pay Plan Logic is set to Do Not Age (Legacy)).
   o Click OK.
An adjustment will be added to future charges in the Amortization Schedule and Payment Plan Procedures and Credits window, reducing the Terms Total Amount and the Total Tx Amt. See Payment Plan (239).
4. Click OK to close.

Adding a payment plan adjustment prior to version 18.1:
1. Add the adjustment to the patient's account, Adjustment.
2. Open the patient's payment plan.
3. Click view TxCredits.
   o Add a negative credit amount.
   o Enter the date of the adjustment.
   o Enter the amount of the discount (e.g. -20).
   o If desired, add a note (e.g. courtesy discount).
   o Click Update.
   o Click OK.
4. On the Patient Payment Plan window, update the Terms Total Amount.
5. Click Recalculate to update the amortization schedule, then click OK. Recalculating Payment Plans (253)
6. Click OK to close.

I have created a negative payment plan adjustment, but need to associate the adjustment to a procedure on the payment plan. How do I attach the adjustment to a procedure?
If you checked Also make line item in Account Module when the adjustment was created, double-click into the adjustment from the Patient Account grid and click Attach.

I only see completed procedures in the Payment Plan Procedures and Credits window but I need to create a tx credit for adjustment charges too. How do I include adjustments?
Tx credits may not be created for adjustment charges. Instead, attach the adjustment to a procedure then create a tx credit for the procedure. Future payments will be split directly to the procedure and adjustment. If you cannot attach the adjustment to a procedure, do not include the adjustment charge in the payment plan principal balance. Creating an unattached tx credit will prevent payment plan payments from being allocated to the adjustment and the adjustment will remain as an outstanding charge in the payment window.

Payment Plan Payments
I attached a payment to a payment plan by mistake. How do I detach it?
For each pay split in the payment, detach the payment plan:
1. Open the payment.
2. Double click on a Paysplit (161).
3. Uncheck the Attached to Payment Plan box.
4. Click OK to save.

The patient wants to pay off the payment plan. How do I determine how much is owed?
The Balance column in the main Payment Plan grid shows the amount that will pay off the payment plan at that exact moment. However, it does not account for any mismatches between Tx Completed Amt and the PrincPaid amount, so closing a payment plan may incur a charge that is different than the Balance.
In a [Payment Plan](239), click **View Tx Credits**.

Associate procedures and other credits to the Payment Plan. The total amount of credits attached determines the amount subtracted from the patient balance.

**Print**: Print a list of the procedures and credits that currently show in the Available Procedures/Payment Plan Credits grid.

**Hide Unattached Procedures**: Only show procedures that are already credited to this plan.

**Show procedures that have not been explicitly paid off**: Show all procedures that do not have enough attached credits (e.g. pay splits, adjustments) to cover the full cost of the procedure.

**Available Procedures**: View all treatment planned and completed procedures that have a remaining patient portion due (yellow).
- Date: The procedure date.
- Provider: Abbreviation of the provider that completed the procedure.
- Code: The procedure code.
- Fee: The original procedure fee.
- Rem Before: The estimated patient portion after insurance estimates, write-offs, and allocated payments are applied.

**Payment Plan Credits**: View all credits (blue) attached to this plan.
- Credit Date: The date the credit will appear on the account.
- Amount: The total amount of credit applied. Typically the Rem Before and Amount will match.
- Rem After: If attached to a procedure, the remaining amount due on the procedure after the credit is applied. Typically it will be zero.
- Note: The note entered with the credit information (see below).
- Payment plan adjustments show as credits on the date they are created and include an adjustment note.

**Credit Information**: Add, update, or remove credits in the Payment Plan Credit column. Credits can be attached to
available procedures or unallocated. If unallocated, payment plan payments will not be split to specific adjustments or procedures. Note: Adjustments must be attached to procedures (e.g. finance charges or sales tax) in order to include them in the payment plan principal balance.

- **Code:** If the credit is attached to procedure code, the code will show. Otherwise it will show Unattached to indicate unallocated.
- **Date:** This date determines when the credit will be applied to the account. If attached to a completed procedure, it defaults to the completed procedure date. If attached to a treatment planned procedure, it will show None but will automatically update once set complete. If left blank, it defaults to today's date. Note: Backdating payment plan credits or changing payment plan credits in the past will change historical aging.
- **Amt:** The total credit amount to apply.
- **Note:** If attached to a procedure, defaults to the procedure code and a shorthand description. If credits show in the patient's account ledger, this note will show in the Description column for PayPlan: Credit line items.

To add a credit for a procedure, highlight the procedure first. The credit fields will populate with the procedure information. Modify if needed, then click **Add**.

To add an unallocated credit, make sure no procedures are highlighted (click **Clear**). Enter the credit information and click **Add**.

To update an existing credit, first select it. Add will change to Update. Modify information as needed, then click **Update**. Note: Updating a payment plan adjustment will not automatically update the amortization schedule or the patient account. Manually update the adjustment in these places.

To remove a credit, highlight it then click **Delete**.

When you click OK, if a procedure's provider is different than the payment plan's provider, Open Dental will warn you. If you proceed (click Yes) the payment plan provider will be assigned to the payplan charges. Future payment splits, however, will be allocated to the procedure provider when the Enforce Valid Paysplits **Account Module Preferences** (693) is set to something other than *Don't Enforce*. Income transfers may also be incorrect. See **Payment Plan Q and A** (255).

**Reversals**

Open Dental does not currently support automatic reversals for attaching payment plan credits to payment plans, but reversals can be made manually.

---

### Insurance Payment Plans

Insurance Payment Plans can be used to track expected insurance payments (e.g. insurance installment payments).

In the **Account Module** (150) Payment Plans grid, they show with a Type "Ins".

<table>
<thead>
<tr>
<th>Payment Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
</tr>
<tr>
<td>06/27/2018</td>
</tr>
</tbody>
</table>

Note:
The grid can also list regular **Payment Plans** (239) and **Installment Plans** (260).

For example, insurance may pay $1000 towards orthodontics, but pay it in four installments of $250 each. Tracking expected insurance payments is especially useful in orthodontics. The outstanding balance of procedures sent to insurance will be removed from the patient's ledger so the patient doesn't appear to owe money on those procedures. Insurance payments for those procedures also do not appear in the patient ledger (otherwise the patient would end up with a negative balance). Close payment plans no longer being paid on. Any difference between the outstanding pay plan charge and the amount insurance paid is moved to the patient ledger, making the patient responsible for any remaining balance.
General Steps:
1. Create and send the claim. Each claim can only be associated with a single payment plan.
2. When the first insurance payment arrives, set up the insurance payment plan.
3. Receive and finalize the first insurance claim payment. See Finalize Insurance Payment(231).
4. As you receive additional payments, add Supplemental Insurance Payments(237) for the payment amount.

- Note: As long as the patient on the claim matches the patient on the payment plan, and the payment plan has a balance, the payment will automatically attach to the payment plan.
- Run the Insurance Payment Plans Past Due Report(1337) to view patients with insurance payment plan amounts past due.

Set up the Insurance Payment Plan
When you receive the first insurance payment and EOB, set up the insurance payment plan.

Select the patient. In the Account Module(150), click Payment Plan, Insurance Payment Plan.

For a description of all fields, see Payment Plan(239).

Category: Assign a category to this payment plan (e.g. Ortho, Implant). Useful to distinguish one payment plan from another when families have many plans. Customize category options in Definitions: Payment Plan Categories(878).

Provider: Verify the provider.

Clinic: If using clinics, verify the clinic.
**Insurance Plan**: Click **Change**, select the insurance plan this payment plan is for, then click **OK**.

**Total Amount**: Enter the total amount of expected payments.

**Date of First Payment**: Enter the date the first insurance payment is received (e.g. today's date).

Enter the expected **Number of Payments** or expected **Payment Amt**.

Click **More Options** to select the frequency of payments. The default is monthly.

Click **Create Schedule** to create the amortization schedule.

**Tx Completed Amt**: Enter the total amount of all insurance payments. This is the amount that will be subtracted from the patient's account balance.

Click **OK** to save the plan.

- Note: If, for some reason, insurance pays less than originally stated, you have two options. 1) Adjust the Tx Completed Amt in the payment plan to transfer any remaining due amounts to the patient. 2) Add a payment plan adjustment to discount remaining due amounts. The Total Amount and Total Tx Amt will automatically adjust for the discount.
- To track insurance payments for procedures on multiple claims, create a payment plan for each claim.
- This method does not work with the **Enforce Valid Paysplits - Enforce Fully, Account Module Preferences**(693).

Attaching/Detaching Payments to or from Plans: If you create the claim payment before you create the insurance payment plan, the payment will not automatically attach to the payment plan. To manually attach, open the claim payment, double click the procedure to open the **Claim Procedures (claimprocs)**(221) window, then check **Attached to Insurance Payment Plan**.

To detach a payment from an insurance payment plan, open claim, double click the procedure to open the Claim Procedure window, then uncheck **Attached to Insurance Payment Plan**.

**Troubleshooting**
When entering the insurance payment, it does not automatically attach to the payment plan even though there is a balance on the plan.
- First check that the Tx Completed Amt in the insurance payment plan matches the Total Amount of expected payments.
- If the Tx Completed Amt is 0, you will be unable to attach the payment to the plan.

**Installment Plan**
In the **Account Module**(150) toolbar, click Installment Plan.
Installment Plans are a quick and easy alternative to Payment Plan (239). They allow you to bill patients an agreed monthly amount. Statements will show the fixed monthly amount due at the top. Additional charges posted after the installment plan creation date will not affect the monthly due balance, nor will missed payments.

**Date of Agreement / Date of First Payment:** Auto-filled with today's date.

**Monthly Payment:** The monthly payment amount.

**APR:** The annual percentage rate (APR). When you use the Finance Charge tool for an account that has an installment plan setup for any family member, this APR is used instead of the APR set in Billing/Finance Charges (1428).

**Notes:** Any notes you wish to keep on file about this installment plan.

Click OK to save.

**Quick Procs**

In the Account Module (150), click Quick Procs.

Use the Quick Procs button to quickly add procedures to the patient's account. This is useful to add retail items such as toothpaste or to add procedures that were not added via the Chart module.

**Add Quick Proc Items to the Patient's Account**

To show the Quick Proc tool button in the Account module toolbar, the logged on user must have the Account Procs Quick Add security Permission (1118). Open Dental must be restarted any time this permission is added or removed for it to take effect.
There are two ways to add Quick Proc items.
1. Click the Quick Procs dropdown to select an item. The dropdown options are set up in Definitions: Account Procs Quick Add.
2. Click the Quick Procs button (not the dropdown), type the full procedure code in the box, then press Enter. Codes are case sensitive. Only users with the Create Completed Procedure security permission have this option.

- Note: Any procedures added using quick procs will have a status of complete and will also show in the Chart Module.
- If you add a procedure that requires a tooth or surface, you will be prompted with a message to fix the tooth number or surface. Click OK, then enter the information on the Procedure Info Window.
- When added to the patient's account, the procedure description will always match the procedure code's description, not necessarily the definition's name.
- The provider assigned to the procedure defaults to the patient's primary provider, unless the procedure code has a provider assigned. Double click a procedure to change the provider.
- Every time a quick proc item is added to a patient's chart, a log is created in the Audit Trail.

**Set up Quick Proc Items**
All quick proc items must have a procedure code.
1. Create new procedure codes for any quick proc items that don't already exist in the procedure code list. You can use any code you want, though you may want to consider using codes that are easy to type.
2. Set up items that show in the Quick Proc dropdown. See Definitions: Account Procs Quick Add.

**Repeating Charge**
Set a procedure to automatically post to a patient's account every month.

In the Account Module toolbar, click Repeating Charge.
To use the repeating charge feature for the first time, it must be enabled. In the **Main Menu** (592), click Setup, Advanced, **Show Features** (806), and check Repeating Charges. The Repeating Charge button will be added to the Account module toolbar.

Once enabled, create a repeating charge on each patient’s account:

Select the patient and from the Account module, click Repeating Charge. The **Procedure Codes - Fee Schedules** (1195) window will open.

Select a repeating procedure that has a treatment area of mouth (cannot require a tooth number, surface, arch, or quadrant). The Edit Repeat Charge window will open.

**Charge Amount**: Enter the amount the patient will be charged every month. Or in the **Calculate Charge Amount** section, enter the Total Amount (procedure fee), the Number of Charges (the number of times the procedure will be charged to the patient), and click Calculate to automatically fill the Charge Amount.

**Date Start/Date Stop**: Enter the dates the first and last procedure will be posted. The procedure will post on the same day of the month on and between the dates entered. For example, a 10/01/2018 start date will result in a charge on 10/01, 11/01, 12/01, etc. with the final charge posting on 09/01/2019. Choose a standard day (typically the same day **Billing** (504) is run) to include the procedures on patient statements.
**Creates Claim:** Check to automatically create a claim for the procedure. The patient must have insurance and the procedure cannot be marked *Do Not Bill to Ins*. The Date of Service will be the procedure posted date and the claim status will be Waiting to Send. If the patient has a secondary insurance plan, a secondary claim will also be created with a status of Hold.

**Use Unearned:** Check to automatically allocate a *Prepayment* (191) (unearned income) to the procedure as it is posted. Note: If both *Create Claim* and *Use Unearned* options are checked, the amount allocated for the unearned amount will only go up to the estimated patient portion. This amount may be less than the user specified *Charge Amount*.

**Unearned Types:** Select a specific unearned income type to be allocated to the repeating procedure. Any unearned payment on a family member matching the selected unearned income type will be used. To allocate any prepayment regardless of unearned type, select All. Additional unearned/prepayment types can be added in Definitions: PaySplit Unearned Types (880).

**Note:** (optional) Enter a repeating charge note. Check *Copy note to procedure billing note* to add to the Billing Note on the Procedure - Misc Tab (315) every time the procedure is posted to the account.

Click OK to save. Repeat steps to add more than one procedure. The repeating charge details will show in the Repeating Charges grid at the top of the Account module.

After repeating charges are set up, run the repeating charges tool to post the procedures to each patient's account, see Repeating Charges (1465). Or, enable the automated repeating charge Account Module Preferences (693) and set repeating charges to run automatically at a specific time each day. Procedures can manually be posted from the Edit Repeat Charge window. Double-click into a repeating charge and click *Manual*. The procedure will be added to the account for the patients primary provider and allocate unearned income (if enabled) but will not automatically create a claim or be marked as *(unsent)*.

**Note:** If a repeating charge is manually posted on a different day than listed in the Date Start field, the repeating charge tool will post a duplicate procedure.

Optionally, set up CC Recurring Charges (1430) to pay the repeating charge balance using the patient's payment information on file. Authorize Recurring Charges (281) for the repeating charge amount and set the recurring charge date to match the repeating charge date. When the recurring charge tool is run, the patient will be charged for the amount up to the repeating procedure fee.

To disable a repeating charge, double-click the procedure in the Repeating Charges grid and uncheck *Enabled*. The repeating charge will still show but will not post to the patient's account. To remove the repeating charge all together, double-click and *Delete*.

**Statement Window**

In the Account Module (150) toolbar, click the Statement dropdown.
**Statement button:** Immediately prints to default printer.

**Walkout:** Immediately prints a Walkout Statement which does not include payment options.

**Email:** Generates PDF attached to an email. The subject and body are automatically filled in based on Billing Defaults, but can be edited before sending. To securely email statements, see Electronic Billing. Regular email is not a secure method of sending statements (PHI).

**Receipt:** Immediately prints Receipt with today's payments.

**Invoice:** Shows Invoice with selected procedures, usually for foreign countries.

**Limited:** Only shows transactions associated with selected procedures, including adjustments, claim payments, and patient payments. If no procedures are selected the window below will appear.
Filters: Adjust From and To date, and Transaction types to filter displayed procedures.
All: Select on displayed procedures.
None: Deselect all procedures.
Click OK to generate limited statement for selected procedures.

The statement will not include aging or payment plan information. The total due, insurance estimate, and balance information is based on the items in the statement only.

More Options: Shows the window below to let you customize a statement prior to printing or sending.
Alternatively, this window also opens when you double-click a bill in the Bills List (Billing List(507)). A read-only window also opens when you double-click an existing statement, invoice, or receipt.

Below is a description of all options that might show on the window. Not all options show for all statement types, and not all options can be modified.

- **Date**: Defaults to today's date.
- **Sent**: Automatically checked once the statement, invoice, or receipt is printed or emailed. It can also be changed manually.
- **Mode**: The method of delivery.
- **Hide payment options**: Remove payment information (amount due, date due, amount enclosed, and credit card payment section, aging).
- **Single patient only**: If checked, only the selected patient's procedures are included. If unchecked, procedures for all family members are included.
- **Intermingle family members**: If checked, all patients in the family are mixed in one grid. If unchecked, each family member has their own grid. Set the default setting in Manage Module Preferences(744).
- **Receipt**: Create a Receipt instead of a statement. Receipts only include patient payment information.
- **Send Text Message**: Send a text message to the patient about this statement. Only works when sending statements from the Billing List(507). Set the default text message in Billing Defaults(510), SMS Statements. The message can include a clickable URL to access an online version of the statement. See Online Payment(1569).
• **Send to Super Family**: Only an option if the patient is a member of Super Family (143) and the family guarantor has Included in Super Family Billing checked on the Edit Patient Information (62). If checked, a super statement that includes account activity for all super family members will be generated. Super statements always group by super family guarantor.

• **Include Patient Last Name**: Include patient's last name in Patient column of the statement.

• **Limited Statement**: Indicates the statement is a limited statement. Only shows for limited statements.

• **Invoice**: Indicates an invoice. Only shows for invoices. An invoice number will also show.

• **Date Range**: Procedures that fall between the start and end date will show on a statement. Type the dates, or click one of the buttons to insert a date. If either of the dates are blank, it's the same as not putting a limit on the date range. So if both dates are blank, then all procedures will show. Date range is ignored if Only show transactions since last zero balance is checked.

• **Only show transactions since last zero balance**: If checked, all transactions from the last date the account balance was zero will print on the statement. The date range entered will be ignored.

• **Notes**: General notes.

• **Bold Note**: Shows in bold red above and below the family grid. When printing individual statements, there is no way to set a default note or dunning messages. But if you set up your Quick Paste Notes (Quick Paste Notes Setup (1088)) properly, you can fill in a variety of notes in this box using only 2 keystrokes each (? + single letter abbreviation). Default notes and dunning messages can be set as part of the batch billing process.

### Buttons at Bottom

**Delete**: Deletes Statement. If current user does not have the Image Delete Permission (1118) copy saved in Image Folder will not be deleted.

**Print**: Sends to the default printer. The statement is designed to be printed on standard perforated billing paper and to fit inside a standard window envelope. Envelopes and billing paper may be ordered from many companies. We have found FormSource to have good service and reliability. See their OpenDentalHealth Care Form Price List. Their number is 1-800-553-3676.

**Email**: Open the Email window, with a PDF version of the statement, receipt, or invoice attached. The default email message will be used.

**Pat Portal**: Send the statement to the patient's portal. In order to do so, the following criteria must be met:

* The patient portal must be set up. See Patient Portal (1555).
* The patient must have access to the patient portal. See Patient Portal Access (1560).
* In Definitions: Image Categories (869), the Statements category must have Show in Patient Portal and Statements selected.

If criteria is met, a message will give you an option to notify the patient via email that the statement is available:

* Click No to send the statement to the portal without sending a notification email.
* Click Yes to open the Edit Email Message window with a default message notifying the patient about the statement availability and how to access it.

```plaintext
Subject: New Statement Available

Dear Buster Andrews,

A new account statement is available.

To view your account statement, log on to our portal by following these steps:
1. Visit the following URL in a web browser: https://www.patientviewer.com/?ID=4487.
2. Enter your credentials to gain access to your account.
3. Click the Account icon on the left and select the Statements tab.

View: Preview the statement, receipt, or invoice. Clicking view will open the Fill Sheet window for additional options. Edit any custom Sheet Field Types (1130) then Print or Email to save the changes.

• Print: Sends to the default printer. When printed, the Fill Sheet window will close and the Sent box will be checked in the Statement window. Click OK to save. Click Cancel to mark the statement as unsent.

• Email: Opens the Email window, with a PDF version of the statement, receipt, or invoice attached. The statement sheet name will be used as the email subject. Insert an E-mail Template or create a custom message.
```
• Close: Closes the Fill Sheet window without saving changes to the sheet elements.

Statement
In the Account Module(150), click Statement.
• Alternatively, in the Statement Window(264), click Print for a single statement.
• Or, in the Billing List(507), click Send for multiple statements.

Printed and emailed statements are automatically saved as PDFs in the patient’s Account Module(150) and Images Module(480). They can be reprinted or viewed at a later time.

Setup Options:
• Manage Module Preferences(744): Select what shows by default in statements (e.g. return address, credit card info, payment notes, adjustment notes, procedure breakdown, account number, due dates).
• Account Module Preferences(693): Select whether the Amount Due and Balance take into account insurance estimates (Balances don't subtract insurance estimate). Usually this is unchecked, unless patients are responsible for all treatment as it is done and insurance payments go directly to the patient instead of the dental office.
• Payment Plan(239): Full and walkout statements show payment plan information in a Payment Plans grid. Depending on the Pay Plan Logic, the Amount Due and Balance on the statement may include payment plan amounts due.
• The internal statement sheet is designed to fit in #10 envelopes. To customize statements, see Statement Layout(1186).

Sample Full Statement:
Clinic A
1234 Maple ST
STE 6
Salem, OR 97301
(503)390-1234

Andrew Smith
0000 Walnut DR
APT 0
Salem, OR 97300

STATEMENT
12/14/2017
Account Number 1

<table>
<thead>
<tr>
<th>Amount Due</th>
<th>Date Due</th>
<th>Amount Enclosed</th>
</tr>
</thead>
<tbody>
<tr>
<td>281.47</td>
<td>Upon Receipt</td>
<td></td>
</tr>
</tbody>
</table>

CREDIT CARD TYPE
#
3 DIGIT CVV
EXPIRE
AMOUNT APPROVED
NAME
SIGNATURE

PLEASE DETACH AND RETURN THE UPPER PORTION WITH YOUR PAYMENT

<table>
<thead>
<tr>
<th>0-30</th>
<th>31-60</th>
<th>61-90</th>
<th>over 90</th>
</tr>
</thead>
<tbody>
<tr>
<td>756.47</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
</tbody>
</table>

Total: $756.47
-Ins Estimate: $475.00
=Balance: $281.47

Payment Plans

<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
<th>Charges</th>
<th>Credits</th>
<th>Balance</th>
</tr>
</thead>
<tbody>
<tr>
<td>12/14/2017</td>
<td>#1 Interest 2.19</td>
<td>176.47</td>
<td>176.47</td>
<td></td>
</tr>
</tbody>
</table>

Payment Plan Amount Due: $176.47

<table>
<thead>
<tr>
<th>Date</th>
<th>Patient</th>
<th>Code</th>
<th>Tooth</th>
<th>Description</th>
<th>Charges</th>
<th>Credits</th>
<th>Balance</th>
</tr>
</thead>
<tbody>
<tr>
<td>12/14/2017</td>
<td>Andrew</td>
<td>D9310</td>
<td></td>
<td>consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician (No Bill Ins)</td>
<td>105.00</td>
<td>105.00</td>
<td></td>
</tr>
<tr>
<td>12/14/2017</td>
<td>Andrew</td>
<td>D2740</td>
<td>17</td>
<td>crown - porcelain/ceramic substrate</td>
<td>1,000.00</td>
<td></td>
<td>1,105.00</td>
</tr>
<tr>
<td>12/14/2017</td>
<td>Andrew</td>
<td>Claim</td>
<td></td>
<td>Pri Claim $1,000.00 Preferred Provider Sent Estimated Payment Pending $475.00</td>
<td>1,000.00</td>
<td></td>
<td>1,105.00</td>
</tr>
<tr>
<td>12/14/2017</td>
<td>Andrew</td>
<td>PayPin</td>
<td>Credit</td>
<td>D2740: #17-AllCerCm</td>
<td>525.00</td>
<td>500.00</td>
<td></td>
</tr>
<tr>
<td>12/14/2017</td>
<td>Andrew</td>
<td>PayPin</td>
<td>Debit</td>
<td></td>
<td>176.47</td>
<td>756.47</td>
<td></td>
</tr>
</tbody>
</table>

Scheduled Appointments:
Andrew Smith: Friday, 12/15/2017, 11:10 AM, ParEx, Pro
Receipt

A receipt shows payments made for the current day or date range.

In the **Account Module** toolbar, click the Statement dropdown, Receipt.

This immediately prints to the default printer and only shows today's payments.

To email or print a receipt for a date range:
1. In the Statement dropdown, click More Options
2. On the **Statement Window** enter the **Date Range** and check Receipt.
3. Select the Mode. Defaults to InPerson if no selection is made and the receipt is printed. If emailed, the mode defaults to Email.
4. (optional) Add statement note/bold notes if needed.
5. To preview before printing or emailing, click **View**. Click **Print** to send the receipt to the default printer. Click **Email** to email the receipt as a PDF, see **Email Message Edit**.

![Receipt Image]
Receipts also show payment plan information, insurance estimates, and the patient balance for a single patient. Prepayment amounts for treatment planned procedures do not reflect in the credit and balance columns of the receipt as to not affect the patients’ overall balance (see Hidden Splits(276)). The prepayment details are for informational purposes only. A slightly different version of the receipt is created for Canada, see Canada Receipts. Once printed, the receipt shows as a line item in the Patient Account grid. Double-click to view, reprint, or resend. A PDF of the receipt is also stored in the Images Module(480) under the Statements image category.

To set the default printer receipts print to, see Printer Setup(601).

**Credit Card/ACH Receipts**
Receipts generated from the integrated credit card processing companies can also be printed or emailed but do not include patient account information. After processing a Credit Card Payment(166), click Print Receipt or Email Receipt on the Payment(153) window. These receipts can also be set to automatically print after a successful transaction, see XCharge Setup(178) or PayConnect Setup(171).

To print receipts for successful recurring charge transactions, see CC Recurring Charges(1430), Printing Receipts.

**Invoice**
In the Account Module(150) toolbar, click the Statement(264) dropdown, Invoice.

Invoice will be generated based on selected procedures and adjustments.

- Note: Selecting Invoice before selecting procedures will create an invoice for all procedures and payments for today (unless Super Family(143) billing is enabled).
- Once attached to an invoice, the same procedures and adjustments cannot be attached to a new invoice.
- Printed and emailed invoices are saved as PDFs in the patient account and Images Module(480), Statements image category.
- To reprint, resend, or view, double-click on the invoice number in the patient account.

Setup Options:
- To customize invoices, see Statement Layout(1186).
- Account Module Preferences(693), Invoices’ payments grid shows write-offs: Select whether insurance write-offs show by default.
Change invoice options as needed.

- **Date**: Defaults to today's date.
- **Sent**: Automatically checked once the statement, invoice, or receipt is printed or emailed. It can also be changed manually.
- **Hide payment options**: Automatically checked to exclude amount due, date due, amount enclosed, credit card payment section, and aging information. If unchecked, the entire family balance will reflect in the amount due field which may be different than the invoice total.
- **Single patient only**: Informational only and cannot be changed.
- **Send to Super Family**: Informational only and cannot be changed.
- **Invoice**: Always checked and cannot be changed.
- **Invoice number**: Automatically generated and cannot be changed.
- **Note**: By default shows the Invoice Note set in Billing Defaults(510).
- **Bold Note**: Shows in bold red above and below the procedure grid.

Click **View** to preview the invoice. If a PDF has been created, View will preview the PDF. If no PDF exists, View will preview the Fill Sheet window. Edit any custom **Sheet Field Types** (1130) then Print or Email to save the changes.

Click **Print** to send the invoice to the default Printer.

Click **Pat Portal** to send the invoice to the Patient Portal Feature.

Click **Email** to email the invoice as a PDF.
Click **OK** to generate the invoice without saving, printing or emailing the PDF.

If the Mode is changed on an existing invoice, a new PDF is created.

**Invoice Search**
Set up a Display Field in the Patient Select window to search for patients by invoice number.

**Foreign Users**
The following differences apply to users in other countries.

- **New Zealand and Australia only**: The title is **TAX INVOICE**.
- **All countries outside the US**: If an invoice is printed multiple times, each copy will have the word **COPY** in red at the top. To print the invoice again without the word **COPY**, uncheck the **Sent** checkbox and the **Invoice Copy** checkbox, then print again.

Sample Invoice

<table>
<thead>
<tr>
<th>Date</th>
<th>Patient</th>
<th>Code</th>
<th>Tooth</th>
<th>Description</th>
<th>Charges</th>
<th>Credits</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/09/2012</td>
<td>John</td>
<td>D0150</td>
<td></td>
<td>Comprehensive Exam</td>
<td>64.00</td>
<td>64.00</td>
<td>128.00</td>
</tr>
<tr>
<td>10/09/2012</td>
<td>John</td>
<td>D0330</td>
<td></td>
<td>Panoramic film</td>
<td>88.00</td>
<td>88.00</td>
<td>152.00</td>
</tr>
</tbody>
</table>

Inclusive of GST at 15%
Ortho Case

Ortho case information for a patient includes the insurance plan's orthodontic claim defaults and the patient's orthodontic treatment information (total months, total used, time remaining).

In the Account Module, when *Show ortho case in account module* is enabled, an Ortho Case tab shows next to Patient Account.

Two preferences in Ortho Setup determine if and where Ortho Case information shows:
- *Show ortho case in Account Module*
- *Show ortho case information in the Ortho Chart*

Ortho Case Tab

**Primary/Secondary/Other Ins:** Shows the insurance plan's orthodontic claim information as entered on the Insurance Plan, Ortho tab. Double click anywhere in the area to open the Ortho Patient Setup window.

**ClaimType:** How the carrier wants to receive orthodontic claims (Ortho Claim Type).
- Initial Claim Only: Send a single orthodontic claim for the initial procedure.
- Initial Plus Visit: Send an orthodontic claim manually for the initial procedure and each subsequent visit.
- Initial Plus Periodic: Send an orthodontic claim manually for the initial procedure, then send periodic claims based on a specific frequency, fee, and procedure. This setting makes the patient eligible for the Auto Ortho Tool (Ortho Auto Claims).

The following information may also show:
- **Frequency:** How often the claim will be auto-created (Auto Proc Period). Only shows when claim type is Initial Plus Periodic.
- **FeeBilled:** The procedure fee billed in the claim (Ortho Auto Fee). Only shows when claim type is Initial Plus Periodic.
- **LastClaim:** The last date an orthodontic claim was created.
- **NextClaim:** The date the next automated claim will be created. Only shows when claim type is Initial Plus Periodic.

**Pat Ortho Info:** Displays the patient's orthodontic information once the initial orthodontic procedure has been completed.
- **Total Tx Time:** The patient's total amount of time in treatment time in months and days.
- **Date Start:** The date the initial orthodontic procedure was set complete. See Ortho Setup to select criteria for the default initial orthodontic procedure. To manually enter a different date, enter a date for Ortho Placement Date, then click Override. To reset the default date, click Default.
• **Tx Months Total**: The total number of treatment months. The default is set in Ortho Setup. To manually enter a different total, enter the number of months in Patient Ortho Months Treat, then click Override. To reset the default, click Default. This amount is used to determine the end date for orthodontic claims generated using the Auto Ortho Tool.

• **Months in Treatment**: The number of months since the patient's initial orthodontic procedure was set complete. This number will continue to calculate after the treatment has been completed.

• **Months Rem**: The amount of treatment months remaining.

### Ortho Chart

When *Show ortho case in ortho chart* is selected, an Ortho Info grid shows in the upper left corner of the [Ortho Chart](#)(390). It displays the same Pat Ortho Info that shows in the Ortho Case tab (above)

![Ortho Info](image)

### Hidden Splits

In the [Account Module](#)(150), when a prepayment is attached to a treatment planned procedure, the Hidden Splits tab will show.

![Hidden Splits](image)

For payments to be allocated to treatment planned procedures, you must enable *Allow prepayments to allocate to treatment planned procedures* in [Account Module Preferences](#)(693).

The Hidden Splits tab shows a summary of any patient [Payment](#)(153) allocated to a treatment planned procedure and [Paysplit Unearned Type](#)(880), flagged as *Do Not Show on Account*. These [Unearned / Prepayment](#)(191) types are hidden from the Patient Account tab, most reports, and statements, to not affect the patient balance until the treatment is complete. The tab is only visible when a treatment planned procedure prepayment exists. Create additional treatment plan prepayment types in [Definitions: PaySplit Unearned Types](#)(880). Assign a custom type as the *Default Treatment Planned Procedure Unearned Type* in Account Module Preferences.

To edit or view the original [Paysplit](#)(161) details, double-click the line item under Hidden Splits. A [Receipt](#)(271) also includes the payment details. Run the [Hidden Payment Splits Report](#)(1355) to track accounts with these prepayments.

Once the procedure is set complete, the prepayment transfers to the Patient Account and shows in reports on the transfer date. It will appear as a positive [Income Transfer](#)(199) line item in the Patient Account tab and negative line item in the Hidden Splits tab. Also, the procedure description will no longer show on the original prepayment line item under the Hidden Splits tab since the procedure is detached when transferred.

The income transfer will look like this in the Patient Account:
Credit Card Manage

In the Account Module(150), Main tab, click Credit Card Manage.

The Credit Card Manage window lists Credit/Debit Cards(166) and checking/savings accounts on file for the patient. Card and account entries are automatically added here when you process a XCharge (OpenEdge)(173), PayConnect Window(168), or PaySimple(186) transaction and select Save Token.

When multiple payment processing programs are enabled, each account in the list indicates the program to be used to charge the card. The first 12 digits of each account are masked with X for cards and * for bank accounts.
- **XCharge**: When X, indicates the card token is saved in XCharge.
- **PayConnect**: When X, indicates the card token is saved in PayConnect.
- **PaySimple**: When X, indicates the card token is saved in PaySimple.
- **ACH**: When X, indicates the checking or savings account token is saved in PaySimple.
- **XWeb**: When X, indicates the card token is saved in XWeb.

**Add**: Add payment information without processing a payment. When you click add, if there is only one kind of credit card processing program enabled, then it will continue directly to payment information. If multiple kinds of processing programs are enabled, then it will prompt you to select one from a list.

- **XCharge Add Card**(278)
- **PayConnect Add Card**(278)
- **PaySimple Add Card**(279)

Double-click an added card or account to Authorize Recurring Charges(281).

**Move To Pat**: Move a card or bank account to a different patient.
1. Highlight the card or bank account.
2. Click **Move to Pat**.
3. A verification message will show. Click OK, then select the new patient.
**Up/Down**: To reorder the list, highlight a card or bank account, then click the Up/Down arrows. The order of cards and accounts in the list determines the order in the Credit Card dropdown on the Payment window.

**Close**: Close the window.

---

**XCharge Add Card**

In Credit Card Manage, click Add.

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Add credit and debit cards on a patient’s account without processing a payment through X-Charge.

Enter the credit or debit card information and click OK.

Credit/debit entries are automatically stored when processing a payment and Save Token is checked.

A token is now created for the card, masking the first 12 digits of the card number. The card will now list in the Credit Card Manage window and will be an available payment option in the Payment window.

---

**PayConnect Add Card**

In Credit Card Manage, click Add.
Add credit and debit cards on a patient's account without processing a payment through PayConnect Window (168). A temporary $1.00 authorization hold may show on the patient's card statement, however it will drop off eventually. Credit/debit entries are automatically stored when processing a payment and Save Token is checked.

Enter the credit or debit card information in the PayConnect Window (168) and click OK.

A token is now created for the card, masking the first 12 digits of the card number. The card will now list in the Credit Card Manage window and will be an available payment option in the Payment (153) window.

PaySimple Add Card

In Credit Card Manage (277), click Add.
Add credit and debit cards on a patient's account without processing a payment through PaySimple (186). A temporary $1.00 authorization hold may show on the patient's card statement, however it will drop off eventually. Credit/debit entries are automatically stored when processing a payment and One-Time Payment is unchecked.

Enter the credit or debit card information in the PaySimple Payment Information window and click OK.

A token is now created for the card, masking the first 12 digits of the card number. The card will now list in the Credit Card Manage window and will be an available payment option in the Payment (153) window.

Add an Account
Add checking or savings account information to a patient's account without processing a payment through PaySimple. Bank account information is automatically stored when processing a payment and One-Time Payment is unchecked.

To add bank account information to a patient's account:
1. Select the patient. In the Account module Main tab, click Credit Card Manage.
2. Click Add. Select PaySimple from the list of available credit card processing programs (list only prompts when more than one program is enabled).
3. Click the ACH tab.
4. Select the Account Type and enter the bank account information in the PaySimple Payment Information window.

A token is now created for the account, masking the first 12 digits of the bank account number. The account will now list in the Credit Card Manage window and will be an available payment option in the payment window.

**Authorize Recurring Charges**

Set up a recurring payment to a patient's credit/debit card or checking/savings account for regularly due charges (e.g. payment plans, repeating charges).

In Credit Card Manage(277), double-click a payment account.
Authorize the recurring charge amount and frequency for select patients. On the scheduled payment date, the patient's payment method will be added to the Recurring Charges tool to be processed. Run the tool manually to process the payments or set payments to process automatically at a specific time each day.

- Note: Multiple cards can be setup for recurring charges in a family, but this may cause unexpected behavior when the family balance becomes $0.00.
- When using a single card, adjust Charge Frequency below as required for multiple charges in a single month.

To run the tool and for set up requirements, see CC Recurring Charges(1430).

To set up a recurring payment, enter the Authorize Recurring Charges details then select the Charge Frequency.

**Authorized Recurring Charges:**
- **Payment Plan:** (optional) Attach the recurring charge to a Payment Plan(239). Use the dropdown to select from a list of plans the patient is a guarantor of. The payment will be applied to the payment plan (Payment to a Payment Plan(246)). If no payment plan is selected, a payment will be processed for the patient's balance up to the charge amount entered, but will not be attached to any payment plan or procedure.
- **Charge Amount:** (required) Enter the scheduled payment amount. For payment plans, this is typically the same as the periodic pay plan debit amount. To remove the amount, click Clear.
- **Run charge even if no patient balance present:** (optional) Check to process the recurring charge for the charge amount even if the patient does not have a balance. If the patient has a credit or no balance, the payment will post to the account as an Unearned / Prepayment(191). To disable this option, uncheck the Account Module Preferences(693), Allow specified charges to run in the absence of a patient balance.
  - Note: If checked, and a payment plan is selected, the recurring charge will not be processed if the patient does not have a balance due.
- **Date Start:** (required) Enter the date the recurring charge is scheduled to start. Click Today to insert today's date.
- **Date Stop**: Enter the final payment date. To charge the patient indefinitely, leave blank. The patient will then be charged for any outstanding balance due up to the authorized charge amount. If a payment plan is selected, the recurring charge will automatically end when the payment plan is paid in full.

- **Note**: Enter notes specific to the charge. Notes are only visible in this window.

### Charge Frequency:
- **Fixed day(s) of month**: (default) Click **Add Day** to select one or more days of the month to schedule the payment. The payment will be processed on the day(s) indicated, with the first charge scheduled the month entered in the Date Start field and the last payment in the month entered in the Date End field (i.e., 10/03, 10/18, 11/03, 11/18, etc. with the final payment on 03/03/2019 for the example above). Click **Clear** to remove the selection(s).
- **Fixed weekday**: Check to select a fixed weekday to schedule the payment. Use the dropdown menu to select which day of the week and how often (e.g., every Monday or fifth Saturday).

Click **OK** to save.

To exit the Credit Card Edit window without saving changes, click **Cancel**. To remove the payment information from the patient's account, click **Delete**.

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### Treatment Plan Module

In the Treatment Plan Module, you can manage and prioritize treatment plans for a patient.
Treatment Plan Toolbar
Preauthorization: Send Preauthorization for a procedure.

Discount: Add a Procedure Discount to selected treatment planned procedures.

Update Fees: For this patient only, update all fees and insurance estimates on the selected treatment plan. See also Fees Update.

Print TP: Print the selected treatment plan. Default print options can be set in Treatment Plan Module Preferences.

Email TP: Email the selected treatment plan.

Sign TP: Electronically sign a saved treatment plan.

Note: To customize the printed layout of treatment plans, see Treatment Plan Layout.

Treatment Plans
The Treatment Plans list in the upper left corner lists all active, inactive, and saved treatment plans for this patient.

Active: There can be one active treatment per patient. Procedures attached to appointments are always on the active plan. Only procedures with a Treatment Planned (TP) status can be on an active plan. As procedures are completed, they are removed. The active plan determines the following:

- The default procedures in the Chart module Progress Notes.
- The default procedures drawn on the graphical tooth chart.
- The default procedures when creating an appointment for this patient.
- The default procedures when creating a planned appointment or scheduling an appointment.

Inactive: There can be multiple inactive treatment plans. Procedures on inactive plans can have a status of Treatment Planned (TP) or Treatment Planned Inactive (TPI). An inactive treatment plan can replace the active treatment plan at any time. Simply double-click the inactive plan, then click Make Active Treatment Plan.

Saved: Save a treatment plan so you have a permanent record of it. This is the only way to preserve a treatment plan since completed procedures will be removed from active and inactive plans. Fees in saved treatment plans are not affected when updating fees.

- To save all procedures in a plan, select the treatment plan then click Save TP.
- To only save certain procedures in a treatment plan, select the procedures, then click Save TP.
- To always save treatment plans as PDF files, see Treatment Plan Module Preferences, Save Signed Treatment Plans to PDF.
- Only saved treatment plans can be signed.
- Saved treatment plans reflect the insurance information that was present on the date the treatment plan was saved.

New Treatment Plans: Treatment plans can be created from this module or from the Chart module in Treatment Plan view. To create a new treatment plan from here, click New TP.

Estimates as of: This date picker only shows if Frequency Limitations is enabled. Use this feature to calculate insurance estimates as of a certain date. Click the dropdown to select the date, then Refresh to update calculations based on the date.

Refresh: Refresh treatment plan and deselect any highlighted procedures.

+Plan Appt: Create Planned Appointments.

Show / Sort / Printing Tabs
Show: Options selected on the Show tab affect what shows in the Procedures grid and printed/emailed treatment plans.

- Graphical Completed Tx: Show completed treatment plan procedures on the printed Graphical Tooth Chart. Set the default in Treatment Plan Module Preferences.
• **Use Ins Max and Deduct:** Indicate when a patient's insurance maximum or deductible has been applied or reached. Only visible when patient has insurance.

• **Fees:** Show or hide all fee information.
  - **Insurance Estimates:** Indicates PPO or allowed fee, primary and secondary insurance estimates, and patient portion, if the patient has insurance. If the patient has a discount plan, it shows the discount (DPlan) and patient portion. Checked by default when patient has insurance or a discount plan.
  - **Discount:** Show procedure discount amounts. Can only be checked if there is a discount or write-off in one of the treatment planned procedures.
  - **Subtotals:** Show Subtotals for each priority level.
  - **Totals:** Show Totals at the bottom of the grid.

To set other options that determine what shows on printed treatment plans see Treatment Plan Module Preferences (e.g. show itemized fees or grand total).

**Sort by:** Procedures are always sorted first by priority, then by date. It can further be sorted by tooth number or order of entry. Also see Procedure Sort Order (478). Set the default in Treatment Plan Module Preferences, Sort Procedures By.

**Printing:** Only shows if patient has a treatment plan that was saved prior to version 17.1. Offices who switched from internal treatment plan sheet to custom sheet should check the box for print classic if they want to print the treatment plan as it would have prior to 17.1.

**Preauthorizations**
The box at the upper right shows all preauthorizations for this patient. Double-click a preauthorization to edit.

**Procedures Grid**
When you click on a treatment plan, the associated procedures show in the Procedures grid. To highlight multiple procedures, press Ctrl and click on the procedures, or click and drag. Double-click a procedure to open the Procedure Info window.

The columns that show can be customized in Display Fields (900), TreatmentPlanModule. Options include:
- **Abbr:** The procedure code abbreviation.
- **Appt:** Indicates if the procedure is attached to an appointment.
- **Clinic:** The clinic associated with the procedure code.
- **Code:** The Procedure Code.
- **DateTP:** Date the procedure was treatment planned.
- **Discounts:** Any discounts applied (procedure discounts + any PPO insurance plan write-offs). Not an option if the UCR fees match the PPO fee.
- **Done:** An X indicates a procedure is completed (saved treatment plans).
- **DPlan:** Any discount applied as a result of an in-house discount plan (UCR fee - discount plan fee). This column only shows when insurance estimates is checked under the Show tab, the patient has a discount plan, and the DPlan display field is added to treatment plan module.
- **Dx:** The procedure’s diagnosis.
- **Fee:** The fee charged for the procedure.
- **Allowed:** The PPO fee for PPO plans or the allowed fee for out of network plans. An X will display in this column for procedures marked DoNotBillIns.
- **Pat:** The estimated patient cost.
- **Pri Ins:** The insurance estimates for the insurance plan listed first in the Family Module.
- **Priority:** The procedure's priority level.
- **Prognosis:** The prognosis assigned to the procedure on the Enter Treatment (301) and the Procedure - Misc Tab (315).
- **Prov:** The provider associated with the procedure.
- **Sec Ins:** The insurance estimates for the insurance plan listed second in the Family module.
- **Sub:** An X indicates the procedure uses a substitution code in Lists, Procedure Codes.
- **Surf:** The tooth surface.
- **Tth:** The tooth number.

The pri and sec ins estimates can be misleading if, in the Family Module, the patient has a dental plan listed first and a medical plan listed second. In this particular situation, the Pri Ins column will show the dental plan estimates, and the Sec Ins column will show the medical plan estimates. We recommend listing the medical plan first in the Family Module.
**Set Priority**
The set priority list is used to assign priorities to the procedures on the treatment plan. Select the procedure(s), then click on a priority level. The sort order of the procedures will change accordingly. Priorities can also be set while entering treatment in the Chart module, and on the Procedure Info window.

Priority options can be customized in Definitions: Treat Plan Priorities(893). You can use numbers, letters, or words up to 7 characters. You can change the sort order of procedures according to priority, change text colors, and hide priorities from view. Examples of other possible priority levels are Sched, Wait, Next, ?, Decline, Last, Low, High, NewYear, Urgent, WaitIns, Altern, Plan A, Plan B, RecPlan, and AltPlan.

**Insurance**
The area at the lower right shows remaining family and individual insurance benefits at a glance. For details about how amounts are determined, see Insurance Remaining Calculations(295).

**Note**
The default note is set in Treatment Plan Module Preferences. Any changes made to the note here will be saved for the selected treatment plan. Right-click to add Quick Paste Notes(1088).

**Updating Fees**
There are a few ways to update fees in active or inactive treatment plans (e.g. if fees have increased/decreased or insurance plan or fee schedule changed).

- **Update Fees button:** Update fees for one patient at a time. Designed to be used during the regular six month exam if there are procedures from the last exam which have not been completed and fees are outdated.
- **Global Fee Update in Fee Tools:** Update fees in all active and inactive treatment plans at once.

Fees in saved treatment plans are not affected when updating fees.

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**Edit Treatment Plan**
In the Treatment Plan Module(283), double-click an inactive, active, or saved Treatment Plans to edit.

**Saved Treatment Plans**
In saved treatment plans, the treatment plan's date, heading, note, and responsible party can be changed. Once a saved plan is electronically signed, it cannot be edited unless the signature is cleared.
In the Treatment Plan module, double-click on the saved treatment plan.

If the plan has been signed, click Clear Signature to remove the electronic signature.

Modify the information as needed:
- **Date**: The date of the treatment plan.
- **Heading**: The title of the treatment plan. It will appear at the top of printed and emailed plans.
- **Note**: The note that typically appears at the bottom of the treatment plan. Set the default in Treatment Plan Module Preferences (703). Right-click the note field to insert a quick paste note.
- **Responsible Party**: Only visible if Public Health (71) is turned on in Show Features (806). Click Pick to select the person, other than the patient or guarantor, who is responsible for approving the treatment plan. Click X to clear a name.
- **Presenter**: The user who presented the treatment plan. Defaults to the logged-on user. Click [...] to select a different presenter (Edit Treatment Plan Presenter permission is required). Presenter options include all users, or, users who are associated with the clinic.
- **User Entry**: The user logged on when the treatment plan was saved.
- **Saved Document**: If the treatment plan has been signed and saved as a PDF, this field shows. Click View to open the treatment plan.
- **Procedures**: When a treatment plan is saved, copies of the procedures are created. These procedure copies can be edited without affecting the original procedure at all. For example, the Description can be changed to anything, such as White filling instead of Composite - 4 surf.

In the Treatment Plan module, highlight the saved treatment plan, then double-click a procedure.
Note: To always use simpler language for procedure code descriptions, enter text in the Layman's Term field on the Procedure Code(1200). If the treatment plan has been electronically signed, the signature must be cleared before procedure copies can be edited.

**Active/Inactive Plans**

In treatments plans that are inactive or active, you can edit heading and notes, copy or remove procedures, and make inactive treatment plans active.

Double-click the treatment plan to edit.
Modify the information as needed.

**Heading:** The title of the treatment plan. It will appear at the top of printed and emailed plans.

**Note:** The note that will appear at the bottom of the treatment plan. Set the default note in Treatment Plan Module Preferences.

**Treatment Planned Procedures:** To remove a procedure(s) from the current plan, highlight it, then click the right arrow. To add an available procedure(s), highlight it then click the left arrow. Only procedures added to other active/inactive plans are considered available.

- **Status:** Current status of the procedure.
- **Tth:** Tooth number.
- **Surf:** Surface.
- **Code:** Procedure code.
- **Description:** Description of procedure.
- **TPs:** Number of treatment plans procedure is attached to.
- **Apt:** Appointment status for procedure if attached to an appointment.
  - **U:** Unscheduled List.
  - **S:** Scheduled.
  - **C:** Complete.
  - **B:** Broken.
  - **P:** Planned.

**Make Active Treatment Plan:** Click to make the plan active.
Editing procedures in an inactive or active plan will also change the original procedure. In the Treatment Plan module, highlight the plan, then double-click a procedure to open the Procedure Info window.

**Sign Treatment Plan**

In the [Treatment Plan Module](#) (283), highlight a saved treatment plan. Click [Sign TP](#).

A saved treatment plan can be electronically signed using a stylus (Windows Tablet PC) or a Topaz signature pad. See [Electronic Signatures](#) (306) for a description of signature options.

By default a single patient signature box will display, but a second signature box for the Staff or Provider presenting the treatment plan can be added.

In each signature box at the bottom of the window, sign the treatment plan.

- Click ✅ to sign using a Topaz signature pad.
- Click ✗ to clear a signature.
- Click OK to save.

To customize the layout of treatment plans, including how to add a second signature box, see [Treatment Plan Layout](#) (1188).

The signature(s) will show when you print the treatment plan.

Sometimes multiple providers need to sign a treatment plan, as in the case of a resident. One solution is for the first provider to make notes and enter their name. The second provider can then sign the treatment plan to approve the note. Notes can be entered on the [Edit Treatment Plan](#) (286) window.

**Print Treatment Plan**

In the [Treatment Plan Module](#) (283), click Print TP.
For setup options, see the following.
- Treatment Plan Layout (1188).
- Treatment Plan Module Preferences (703):
  - Show/don't show completed work on the graphical tooth chart.
Show itemized procedure fees or show total amount only.

- **Definitions: Image Categories** (869): Set the default Images category for PDF copies of printed treatment plans.

In the Treatment plan module, highlight the treatment plan, then click Print TP. The plan will be sent directly to the printer, and will look similar to the following.

The Note box will not show on printed treatment plans if there is no note entered on the Edit Treatment Plan window.

### TP Procedure Discount

In the **Treatment Plan Module** (283), discounts can be applied to treatment planned procedures.

Discounts can be based on a percentage of the total procedure fee or a specific dollar amount. When a procedure with a discount is set complete, an adjustment is automatically added for the discount amount.

The discount feature is intended for use with cash only patients and is not currently programmed to interact with insurance. Use this feature only if you know it complies with your local laws. Laws vary between regions and Open Dental does not differentiate legal and non-legal use of the program. For example, we have been told that it may be illegal to use different fee schedules for cash only patients vs. insured patients.

**Setup**

In **Treatment Plan Module Preferences** (703):

- For percentage discounts, set the default discount percentage (**Procedure discount percentage**).
- Select the default adjustment type to use for procedure discounts (**Procedure discount adj type**).

**Apply a Percentage Discount to Treatment Planned Procedures**

1. In the Treatment Plan module, select the treatment plan.
2. If the discount only applies to specific procedures in the treatment plan, highlight them, or do not select procedures to apply the discount to all procedures in the treatment plan.
3. Click Discount in the tool bar.

4. Verify the discount percentage and change if needed. The default value is determined by the setting in Treatment Module Preferences. Enter 0 to clear all discounts.
5. Click OK to apply the discount to the selected procedures.

The Discount column in the Procedures grid will reflect any discounted percentage amounts + any PPO insurance write-offs.
Apply a Specific Dollar Amount Discount to a Treatment Planned Procedure
1. Double click on the procedure to open Procedure - Financial Tab (312).
2. Enter the specific dollar amount in the Discount field.

Preauthorization
In the Treatment Plan Module (283), with desired procedures selected, click PreAuthorization.

A preauthorization is very similar to an insurance claim, except that when it is sent, the date of service is left blank. The insurance company reviews the procedures sent and decides whether they are covered under the patient's contract. They will send back a form with an estimate of how much will be covered for each procedure.

Note: The Place of Service for preauthorizations can be edited on the claim. By default, preauthorizations in version 16.4.32 or greater and 17.1.3 and greater inherit the Place of Service from the last procedure in the preauthorization claim. In earlier versions, the first option under Default Place of Service in Practice Setup (931) is used by default.
Create a New Preauthorization
1. In the Chart Module (298), treatment plan the procedures.
2. In the Treatment Plan Module, highlight one or more procedures by pressing Ctrl while clicking.
3. In the Toolbar, click PreAuthorization. If there is only one insurance plan, proceed to step 4.

If there is more than one active plan, the Select Insurance Plan window will open:

Select the plan the preauthorization is for, and the relationship of the patient to the plan subscriber, then click OK.
Note: To list all insurance plans for the family, including inactive or dropped plans, check Show plans for family which are not in use by the current patient.

4. On the Edit Claim window, click OK.
5. Print or send the preauthorization electronically. Once sent, only users with the PreAuth Sent Edit permission can make edits.

Manage Preauthorizations
Preauthorizations for a patient are listed in the top right of the Treatment Plan Module. When you click on a preauthorization, all procedures attached to that preauthorization will highlight for easy viewing.

Double click to view or edit on the Claim (208).

Other Coverage: Set other coverage (e.g. secondary coverage) after you create the preauthorization. Open the preauthorization, then at the top of the Edit Claim window, click Change next to Other Coverage. This option can also be used to set primary coverage if this is a preauthorization to a secondary insurance plan.

Receive a preauthorization (when it comes back from the insurance company):
1. Double click on the preauthorization.
2. Click By Procedure in the upper right.

3. Click in the Estimate cell to enter the estimate given on the EOB.
4. For reference, enter the preauthorization number sent by the insurance company and any remarks. When you create the final claim on the Edit Claim window, you will need to enter the number from the preauth note in the **Predetermine Benefits** field.

The estimates will flow into the patient's treatment plan estimates.

**Check Preauthorization Status:** Check the status in the upper right of the Treatment Plan module, or use the **Outstanding Insurance Claims Report** (1315) and include preauths.

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**Insurance Remaining Calculations**

This page explains how insurance remaining estimates are calculated.

In the **Treatment Plan Module** (283), at the lower right, is the Insurace Remaining grid.
Alternatively, in the **Account Module** hover over Ins Rem.

Calculations consider the current benefit year only.

**Primary**: Calculations for the first (primary) insurance plan listed in the Family Module (order of 1).

**Secondary**: Calculations for the secondary insurance plan listed in the Family Module (order of 2).

Procedure estimates are found on the **Procedure - Financial Tab**.(312).

**Family Insurance**

**Annual Max**: The family’s annual maximum. Usually this value is entered in the Family column, Annual Max field on the **Benefits** Window. In the Benefit Information grid, this value corresponds to the benefit that matches the following criteria:
- Level = Family
- Type = Limitation
- Time Period = Calendar Year or Service Year
- Quantity = 0
- Qualifier = None
- Proc Code = None (blank)

If no benefit matches the criteria, the box will be blank. If there are multiple benefits that meet the criteria (e.g. annual maximums for specific categories), the lowest amount shows.

**Fam Ded**: The family’s general deductible. Usually this value is entered in the Family column, General Deductible field on the Edit Benefits window - Simplified View. In the Benefit Information grid, this value corresponds to the benefit that match the following criteria:
- Level = Family
- Category = None or General
- Type = Deductible
- Time Period = Calendar Year or Service Year
- Quantity = 0
- Qualifier = None
- Proc Code = None (blank)

If no benefit matches the criteria, the box will be blank. If there are multiple benefits that meet the criteria (e.g. general deductibles for specific categories), the deductible entered first shows.

**Individual Insurance**

**Annual Max**: The patient’s annual maximum. Usually this value is entered in the Individual column, Annual Max field on the Edit Benefits window - Simplified View. In the Benefit Information grid, this value corresponds to the benefit that match the following criteria:
- Level = Individual
- Type = Limitation
• Category = None or General
• Time Period = Calendar Year or Service Year
• Quantity = None
• Qualifier = None
• Proc Code = None (blank)

If no benefit matches the criteria, the box will be blank. If there are multiple benefits that meet the criteria (e.g. annual maximums for specific categories), the lowest amount shows.

**Deductible**: The patient’s general deductible. Usually this value is entered in the Individual column, General Deductible field on the Edit Benefits window - Simplified View. In the Benefit Information grid, this value corresponds to the benefit that match the following criteria.

- Level = Individual
- Category = None or General
- Type = Deductible
- Time Period = Calendar Year or Service Year
- Quantity = 0
- Qualifier = None
- Proc Code = None (blank)

If no benefit matches the criteria, the box will be blank. If there are multiple benefits that meet the criteria (e.g. general deductibles for specific categories), the deductible entered first shows.

**Ded Remain**: The remaining deductible (family or individual) for the current benefit year. The lowest of the two amounts shows. Only claim procedures with status of Adjustment, NotReceived, Received, and Supplemental are considered. Each calculation is shown below.

- Famil Ded - (all deductibles applied to any family member) = family Ded Remain
- Deductible - (all deductibles applied to the current patient) = individual Ded Remain

**Ins Used**: The patient’s total insurance used for the current benefit year. Only Claim Procedures with status of Adjustment, NotReceived, Received, and Supplemental are considered. If a benefit meets the following criteria it does not affect this calculation.

- Type = Limitation
- For a category other than None or General OR for a specific Procedure Code in a category
- Time Period = Calendar Year, Service Year, or Lifetime
- Quantity = 0
- Qualifier = None

**Pending**: The patient’s total amount of pending insurance. Only claim procedures with status NotReceived are considered. If a benefit meets the following criteria it does not affect this calculation.

- Type = Limitation
- For a category other than None or General OR for a specific Procedure Code in a category
- Quantity = 0
- Qualifier = None
- Time Period = Calendar Year, Service Year, or Lifetime

**Remaining**: The patient’s remaining insurance amount. The calculation is:

Individual Annual Max – (Ins Used + Pending) = Remaining

**Insurance Used vs Pending**

If you drop an Insurance Plan, then add a new identical plan, Ins Used and Pending will appear to show incorrect amounts if the dropped plan is associated with any paid or pending claims in the current benefit period. This is because claims associated with the dropped plan are not used in the calculations. To adjust the amounts, follow these steps.

1. For the new plan, add Adjustments to Insurance Benefits(106) on the Edit Insurance Plan window. Enter the total insurance that has been paid to date, and the total deductible that has been used.
2. In the Account Module, review all sent claims and collect data for any claims attached to the dropped plan that are still outstanding.
3. Delete outstanding claims attached to the dropped plan.
4. Recreate the claims for the new plan.

Chart Module

The Chart Module is where the clinical information is entered and organized for a patient.

See our videos: Chart Module Webinar, QuickTip: Printing Progress Notes

Set default options in Chart Module Preferences. To view only clinical information, see Show Features. Define colors in Definitions: Chart Graphic Colors.

Chart Toolbar

- **New Rx:** Click New Rx to create single Rx / Prescription. Click the dropdown, then Rx Manage to create and print multiple prescriptions at once.
- **eRx:** Create an electronic prescription. Click the drop down, then Refresh to manually copy new electronic prescriptions to the Progress Notes and Medication List.
- **LabCase:** Create new Lab Cases.
- **Perio Chart:** Enter periodontal information in the Perio Chart.
- **Ortho Chart:** Open the Ortho Chart, an alternate method of keeping track of visits. Info entered here does not show in regular patient chart. Click the drop down to open a specific tab when multiple tabs are set up.
- **Consent:** Consent Form.
- **Tooth Chart:** Click the drop down to view a full screen of the tooth chart, or save it as an image.
- **Exam Sheet:** Create an exam sheet.
• **Layout:** Allows switching between different versions of the Chart Layout(460). Click the drop down to select a custom layout. Click the button to create a new layout (stored as a custom Sheet(1123)).

• **EHR:** Launch the EHR Dashboard(400) (EHR users only).

• **Bridge buttons:** If you have set up bridges to other programs, additional bridge buttons may appear. For a list of bridges, see Program Bridges.

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**Graphical Chart**

The Graphical Tooth Chart(464) shows all restorative treatment that has been performed or is planned for the patient. Drag the slider bar under the tooth chart to view procedure changes to the tooth chart over time.

- Customize procedure status colors in Definitions: Chart Graphic Colors.
- Customize the type of graphic on the Procedure Code(1200) (Paint Type).
- Select freehand drawing options on the Draw tab.
- Control which procedures are shown on the graphical chart on the Show tab.
- Text Box: Enter any notes.

---

**Tabs**

To minimize/maximize the tab areas, click the currently selected tab.

- **Enter Treatment:** Enter and chart procedures. Enter Treatment(301)
- **Missing Teeth:** Record missing teeth on the graphical tooth chart. Missing Teeth(323)
- **Movement:** Indicate tooth movement on the graphical tooth chart. Tooth Movements(323)
- **Primary Teeth:** Mark primary/permanent teeth on the graphical tooth chart. Primary / Permanent Teeth(324)
- **Planned Appointments:** If treatment is needed, set up the patient’s next appointment. Planned Appointments(325)
- **Show:** Set up different views for the Progress Notes grid. Show Chart Views(328)
- **Draw:** Freehand draw on the graphical tooth chart. Draw on Tooth Chart(332)

---

**Patient Info**

Patient information is in the lower left. The fields that appear are defined in Display Fields(900). Double-click anywhere in the area to open the Edit Patient Information window.

**Note:** Patient Fields(687) will only show here if you have added PatFields to Fields Showing in Display Fields, ChartPatientInformation.

---

A summary of medical information appears in the pink area. To change the color of the medical area, see Definitions: Misc Colors(876). Double-click on the area to open the Medical Chart(466).

---

**Progress Notes**

The grid title and items that show in the Progress Notes area are determined by the options selected for the active Chart View under the Show tab. The color for specific types of entries can be customized in Definitions: Prog Note Colors(884).

To edit an item in the Progress Notes, double-click on it. Right-click to view additional options.

**Right Click Options:**

- **Delete:** Delete the selected item. Completed procedures and group notes attached to at least one completed procedure cannot be deleted from here.
- **Set Complete:** Set appointments, procedures, and tasks complete.
- **Set Existing Current:** Set a procedure to a status of Existing Current.
- **Set Existing Other:** Set a procedure to a status of Existing Other.
- **Edit All:** Change the date, provider, or clinic (if enabled) for selected procedures.
• **Group Note**: Attach a single clinical note to multiple procedures.
• **Print Progress Notes**: Print the progress notes as they currently show on screen. Each page of the printed notes will include the patient name and page number.
• **Print Day for Hospital**: In Show Features, Hospital must be checked. Print only completed procedures, a photo of the patient (if available), and a signature line at the bottom for the staff to sign.
• **Group for Multiple Visits**: Group together related procedures that are done during multiple visits (e.g. crowns). When a procedure is set complete the procedure status will show as **Complete (In Process)** until all other procedures in the group are set complete as well.
• **Ungroup for Multiple Visits**: Ungroup a procedure that has been grouped for multiple visits.
• **Print Routing Slip**: Print a single routing slip for the selected appointment.

To see the logic behind how procedures are sorted in the Progress Notes, see [Procedure Sort Order](#).

Use the Show Tab, Search box to search through progress notes using a word or phrase.

**Note**: Forms designed using sheets can only be deleted by double-clicking the form, then deleting it from the Fill Sheet window. Deleted sheets are not permanently removed from the database. They can be viewed in Audit mode and also restored if needed.

**Paging** ([&lt;&lt;](#), [ &lt;](#), [ &gt;](#), [ &gt;&gt;](#)): As progress notes become longer, use the arrows or numbers to navigate through progress note pages. Paging only appears if the patient has more than 500 items in their progress notes (commlogs, procedures, tasks, emails, etc).

**Treatment Plan View**
If Treatment Plan is checked on the Enter Treatment tab, the interface changes to Treatment Plan view so you can treatment plan in the Chart module. The check box only shows when **is TP view** is selected in the Chart View (Show tab).

[Treatment Plan in Chart](#)

**Tabs below Patient Info**
The tabs below Patient Info reflect Image categories that have been marked as **Show in Chart module** in [Definitions: Image Categories](#). This is useful to view items like radiographs and photos directly in the Chart module.
• The height of the images section can be made taller or shorter by dragging the splitter.
• To quickly minimize/maximize the area, click on the current tab.
• Click the All tab to show all images for all tabs.
• Double-click an image to open the image full size in a new window. The new window can be dragged to another monitor if multiple monitors are used, and it can remain open while you return to the Chart.
Enter Treatment

In the Chart Module (298), select the Enter Treatment tab.

You can chart planned treatment, treatment that will be referred out, or existing treatment (done at your office or another location). Entered treatment will show on the Graphical Tooth Chart (464) and will list in the Progress Notes.

Webinar: Clinical Charting 1: Entering Treatment

Tooth Surface Buttons (B/F, V, M, O/I, D, L): Click on a button to populate the surface in the box above. To remove an entry, click the button again. The box itself cannot be edited.

Note: The V surface is different than the other surfaces. Open Dental uses V to indicate a class 5 location along the gingival margin of the B or F. The V surface will draw separately on the tooth chart. There is no corresponding lingual class 5 indicator. Since V is not one of the surfaces allowed when submitting to insurance, it will convert to B or F on all claims. Also, you should not count a V as another surface additionally to B or F because no line angles were crossed. For example, you might have a 2 surface DBV, which would be automatically converted to a DB on outgoing claims. V is also not counted as a surface for auto codes. Surfaces are handled slightly differently in Canada.

Entry Status: Determines the procedure status. Set status colors in Definitions: Chart Graphic Colors (855).
- TreatPlan (default): For treatment that is recommended, but not yet complete. Procedure(s) will have an entry date and a fee. If added to the active treatment plan, the status will be TP. If added to inactive plans only, the status will be TPi. If no treatment plan is selected, the procedures are added to the active plan.
- Complete: For work that you have already completed. Procedure(s) will have a fee.
- ExistCurProv: For treatment that was done in your practice prior to using Open Dental. Procedure(s) will have no fee.
- ExistOther: For treatment that was done by another provider, either before the patient came to your practice, or because they were referred out for treatment. Procedure(s) will have no date and no fee.
- Referred: For treatment the patient needs, but will be done at another office. Once the work has been completed, change the procedure status to EO. Referred procedures usually have the date of the referral, but no fee.
- Condition: For charting conditions or watches. See note below.

Note: Conditions and Diagnoses: There are two different possible workflows for charting diagnoses like caries. The simpler workflow is to mark the "diagnosis" on the procedure that is being treatment planned. The other workflow is to enter all the "conditions" in one pass, followed by entry of all the planned restorations. Here’s how to setup and use conditions:
1. Go to Procedure Code List(1195) and make sure a dummy Procedure Code for Caries exists. Search carefully. If you don't see it, uncheck "Show Hidden" and use the search box.

2. If the code truly does not exist, Add Procedure Code(1204), type None. The category will probably be No Fee, or similar.

3. Edit the Procedure Code(1200) to make sure it has a Paint Type of Filling(dark or light), and Treatment Area of Surf.

4. Definitions: Chart Graphic Colors(855) Condition (or light) should have a color like red.

5. Enter like this: Click graphical tooth, click Surfaces, click Condition, click Procedure List, pick the Caries code.

6. To speed up entry, you can add the code to a new Procedure Button(736).

Date/Today: The procedure's entry date. Check Today to insert today's date. To enter multiple procedures with a previous date, uncheck the today box, then enter the date first, before entering treatment.

Diagnosis (optional): One diagnosis can be set per procedure. Diagnoses do not show on the graphical tooth chart. Customize options in Definitions: Diagnosis Types(866). To see diagnoses separately from the proposed treatment, use the Condition (Cn) entry status.

Prognosis (optional): Not used by most offices. Customize options in Definitions: Prognosis(885).

Priority (optional): Used to prioritize treatment planned procedures. Customize options in Definitions: Treat' Plan Priorities(893).

There are multiple optionsto create a procedure:
- Quick Buttons: These buttons are associated with a single code and designed to quickly chart fillings and sealants.
- Procedure Buttons: These buttons are associated with multiple codes or Auto Codes and organized by category. see Procedure Buttons(736).
- Procedure List: Select a code from the Procedure Codes(1195).
- Type Proc Code: Manually type the code then click OK. If a D code, entry of the D is optional. If the procedure requires a tooth surface, you can click surface buttons before clicking a button or entering the code, or you will be prompted to enter surfaces after.

Treatment Plans: Check this box to show treatment plan information in place of the Progress Notes. See Treatment Plan in Chart(462). This check box only shows when Is TP View is also selected for the Chart View on the Show tab (Show Chart Views(328)).

Entering Treatment
When entering a procedure code for one tooth, select the tooth from the graphics. Select multiple teeth if entering the same procedure for each tooth.

When entering a procedure for a tooth range, select the range of teeth from the graphic. The selected procedure code will automatically enter the teeth into the treatment area.

When entering a procedure for a quadrant, select any tooth in that quadrant. When entering a procedure for an arch, select any tooth in that arch. The charted procedure will then automatically enter the correct treatment area.

By default, procedures will chart with a status of Treatment Planned. Double-click a procedure to manually change the procedure status.

Procedures will chart with today's date. Double-click a procedure to manually change the date. To change the date on multiple procedures, right click and select Edit All.

The procedure will list in the Progress Notes and show on the tooth chart (if applicable). If information is missing, the Procedure(303) will open so you can fill it in. Double-click a procedure to edit it.

Change Code Recommendations
If using Auto Codes(813), you may receive a prompt to change a procedure code if Open Dental has recognized a mismatch. For example, if you select three surfaces for a two surface procedure code, Open Dental will prompt you to change to the recommended three surface procedure code.
To set whether or not staff is required to accept auto code suggestions, see Chart Module Preferences (706), Require use of suggested auto codes.

**Procedure**

In the Chart Module (298), double-click a procedure to edit.
The procedure edit window can also be opened from the Account and Treatment Plan Modules.

Procedures are usually entered in the Chart Module using the **Enter Treatment** (301) tab.

To edit, delete, or set procedures complete, the logged on user must have the correct security permissions. Once procedures have been attached to a claim, a note will show at the bottom of the Procedure Info window warning you that certain fields should not be changed. These fields will be grayed out. To make changes anyways, click **Edit Anyway**.

**Date Entry**: Initially this date is the day the procedure was entered. The date is updated when the procedure is set complete. It cannot be manually edited.

**Date TP**: The day the procedure was added to the treatment plan.

**Date**: Date of the procedure.

**Time Start**: Enter the start time. End, Now and Final only show when **Medical Insurance** (128) is turned on. Now inserts the current time. The Final field automatically calculates the total minutes.

**Original Date Comp**: Only shows for procedures that are complete, if the Date changes.

**Procedure/Description**: Click **Change** to select a different procedure code from the **Procedure Codes** (1195). This will also update the Amount field. If the new code’s treatment area is different, you will not be allowed to change it due to a treatment area mismatch. For example, you cannot change a filling procedure to a prophy procedure, because the treatment area for a filling is Tooth and for a prophy is Mouth. Once you attach a claim to an incorrect procedure, it is more complex. See **Incorrect Procedures on Claim** (225).
**Multiple instances of same procedure:** Sometimes you need to add the same procedure multiple times, such as when administering many units of anesthesia. In these cases, add the procedure once, then change the Unit Quantity on the Procedure - Medical Tab(314) to account for the additional units. For example, to add 45 minutes of D9221 (deep sedation/general anesthesia - each additional 15 minutes), add the procedure once, then enter 3 as the Unit Quantity.

For guidelines on entering procedures that involve multiple appointments, see Procedure over Multiple Appointments(321).

**Tooth/Surface:** Options for tooth number and surfaces are different depending on the procedure code’s Treatment Area.
- **Tooth:** A single tooth number. This is required if treatment area is set to tooth.
- **Surfaces:** B/F, V, M, O/I, D, L. Enter or click a button to select. Click again to clear. This is required if treatment area is set to surface.
- **Quadrant:** UR = upper right, UL = upper left, LR = lower right, LL = lower left.
- **Sextant:** 1 - 6 in United States. 03 - 08 in Canada. This is required if treatment area is set to sextant.
- **Arch:** U = upper, L = lower. This is required if treatment area is set to arch.
- **Tooth Range:** 1 - 32 or A - T. Click and drag to select a range of teeth.

To use international tooth numbers, or for information on valid tooth numbers or supernumerary teeth, see Chart Module Preferences(706), Tooth Nomenclature.

**Amount:** The billable fee of the procedure based on the fee schedule. Enter default fees in the Procedure Code List. The fee only shows if the logged on user has the Show Procedure Fee security permission.

**Hide Graphics:** Check this box to hide this procedure on the Graphical Tooth Chart.

**Clinic:** The clinic associated with this procedure. Only visible when Clinics is turned on.

**Provider:** The provider associated with the procedure.
- Set the default prompt and behavior for fees when changing the provider on a procedure using the Procedure Fee Update Behavior preference in Chart Module Preferences.
- If using clinics and providers are restricted to clinics in security, only providers available for the selected clinic are options.
- If the procedure is set complete and attached to a pay split, changing the provider here will also change the provider on the attached pay splits.

**Diagnosis:** You can select one diagnosis per procedure. If a procedure requires more than one diagnosis (for instance: cracked tooth, IP, Apical perio) add them as notes. Diagnoses do not affect the graphical tooth chart. Customize options in Definitions: Diagnosis Types(866). To see diagnoses separately from the proposed treatment, see the comments regarding the Condition (Cn) Status.

**Priority:** Used to prioritize treatment in the Treatment Plan module. Options can be customized in Definitions: Treat' Plan Priorities(893).

**Prosthesis Replacement:** Only visible if the procedure code has been setup as Is Prosthesis. This information is sent in e-claims only and is required before sending electronically. If Replacement is selected, an Original Date is required. To flag the date as estimated, check the Is Estimated box. The flag is only supported in 5010 e-claims. For 4010 e-claims, there is no place to send this flag, but it may be useful for documentation. Enter this information for printed claims on the Edit Claim - General Tab(213).

**E-claim Note:** A place for short notes that pertain to this procedure. Limited to 80 characters. It should be used rarely and is only sent in e-claims; it will not print on paper claims. The note is procedure level, not a claim level. To enter a claim note, see Edit Claim - General Tab(213).

**Procedure Status:** The procedure status can be one of the following:
- **Treatment Planned (TP):** For work that is recommended, but not complete yet.
- **Complete (C):** The work is done and will show in the patient's account.
- **Complete (In Process) (C/P):** The procedure has been grouped with other related procedures. Implies other work must still be completed before a claim can be sent. (e.g. crowns).
- **Existing-Current Prov (EC):** Procedure was done in your practice before you started using Open Dental.
- **Existing-Other Prov (EO):** Procedure was done by another provider, either before the patient came to your practice, or because they were referred out for treatment.
• Referred Out (R): Procedure the patient needs, but that will be done at another office. Once the work has been completed, you can change the status of the procedure to EO.
• Condition (Cn): Chart caries and other conditions as a separate step in order to see them on the graphical tooth chart. Most offices will not use this status. To use this status, you must also add dummy procedure codes that represent the conditions you are trying to show. The mouth area and paint type of each dummy code must be carefully set.
• Treatment Planned Inactive (TPi): Procedures that are not part of an active treatment plan.

The procedure status determines the color used on the graphical tooth chart. Manually changing a procedure status to Complete only changes the status. It does not change procedure dates or copy default procedure notes.

Set Complete: Assign the status of complete, insert default procedure notes, change the Date Entry and Date to today's date, and close the window.

Referral: Click [...] to refer this procedure to a Referral source. Referrals out can be tracked individually.

User: Identifies the User last associated with the Notes and tied to any electronic signature (below). Defaults to the logged-on user. To override the user, click [...] then enter log-on credentials.

Auto Note: Click to manually insert Auto Notes(317).

Edit Auto Note: This button only appears if an Auto Note has been used. Click to complete Auto Note that may have been left unfinished.

Notes: For Procedure Notes. Usually empty until the procedure status is set complete. Once set complete, default procedure notes are automatically copied and staff can make changes to the notes as needed.
• To create default procedure notes, see Procedure Code(1200).
• If a default procedure note contains an auto note (and the preference Procedures Prompt for Auto Note in Chart Module Preferences is checked) reopening the procedure will trigger any auto note prompts.
• If a note contains quotes “”, then information must be filled in between the quotes or the note is considered Incomplete. To print incomplete notes, see Incomplete Procedure Notes Report(1300).
• If EHR is turned on, this box can be searched. Click Search, enter the search string, then click OK. The first matching result will highlight.

Signature/Initials: Sign the note electronically (see Electronic Signatures(306)). The user tied to the note is indicated in the User box above the Notes area. If a note is edited later, the signature will be cleared.

Tabs:
• Procedure - Financial Tab(312): View and add insurance estimates, adjustments, payments, and TP Procedure Discount (292).
• Procedure - Medical Tab(314): To view this tab, Medical Insurance must be turned on. Use it to attach ICD-10 diagnosis codes to the procedure (if required by insurance) or enter other medical claim information.
• Procedure - Misc Tab(315): Medicaid and public health options.

Delete: Hide this procedure. The procedure will appear to be deleted, but will actually be hidden. Be very careful to make sure you don't lose any clinical information and that the Account remains accurate. Deleted procedures can only be viewed in Audit mode on the Show Chart Views(328).

Electronic Signatures

In the Procedure(303) Edit window, on the right, is a signature box.
Anelectronicsignaturecanbeusedmuchlikeapenandpapersignature.Eachsignatureiselectronicallylinkedtothedatatappliestoand,ifthedatachanges,thesignatureisinvalidatedorcleared.

When electronic signatures are available, a signature box shows:

Options:

- Sign with a Topaz signature pad.
- Clear a signature.
- Add an electronic signature stamp for the person currently logged in. Digitally Signed by [logged-on user] Date Signed: [today's date and time]. Only visible for procedure notes if Allow digital signatures is turned on in Chart Module Preferences (706).

We recommend using a Topaz signature pad for electronic signatures, but you can also use a stylus on a tablet PC or similar touch screen. When signing with a stylus, information about the speed of each stroke is recorded.

- Note: Sometimes the user logged on when an item is electronically signed is also linked to the signature (e.g. commlog). In other areas, such as Procedure notes, the person signing can override the logged on user before signing.
- If electronically signing a form designed using Sheets (1123), the date and time of the signature will show in the signature box once the signature is saved (not payment plans).
- If data tied to a signature is changed behind the scenes, signatures will be marked invalid instead of being cleared.
- Signatures created using a mouse, or by marking a check box, are still valid electronic signatures, but with just a mouse signature or click, it is not possible to verify the person signing with the signature alone.

**Topaz Signature Pads**

Open Dental does not sell the Topaz signature devices. However to ensure compatibility, please make sure the model number you order exactly matches a signature pad we recommend. We recommend purchasing new models only and verifying the warranty.

Purchase in the United States and Canada: Topaz Website

Requirements: The pad you purchase MUST be a 1 x 5 pad and it MUST have a model number ending in HSB or BSB. Those models are all USB types that use the human interface driver.

HSB model setup: See Topaz HSB Model Setup (311). This is our recommended signature pad model.

BSB model setup: See Topaz BSB Model Setup (308).

Older versions of Windows and Windows 7 (64 bit) will work fine with the included or downloadable drivers. If you have Windows 7 (32 bit) then you will need to call Topaz for the drivers, as they are not included on the disk or posted on their website.

Topaz Pad Recommendations: At this time, we strongly recommend a wired pad as we have not found a wireless pad that is functional. This table has been omitted.

Other pads may have extra features, such as backlighting or more durable surfaces. These pads will work as long as they meet the Requirements listed above. This table has been omitted.

**Technical Details**
Topaz pads now work with 64 bit versions of Windows, but only starting with version 6.9 of Open Dental. Earlier versions of Open Dental only support Topaz on 32 bit versions of Windows.

**Topaz BSB Model Setup**

This is the basic setup process of the Topaz T-S460-BSB-R for use with Electronic Signatures. May apply to other models that are meant to work with Remote Desktop Connection (RDC). Unlike the Topaz HSB models, this BSB model works with Microsoft's Remote Desktop Services and RemoteApp with the Terminal Services role turned on (i.e., more than one remote client session on the same server). Terminal Services Users must use this model instead of the HSB models.

Topaz BSB model digital signature pads only work with Open Dental version 15.3 or greater.

To get started setting up a Topaz BSB signature pad for use on a Terminal Server:
1. Open the Topaz Setup Instructions (PDF).
2. You will likely be following the instructions for terminal server. If so, skip step three.
3. Complete the steps laid out in the PDF.

See Server Setup and Workstation Setup below.

**Server Setup**

Set up the server once, then follow the workstation setup steps for each workstation. The steps below are required.

Log into the server, then download and save SigPlus.exe.

If using Server 2003
1. Open Add/Remove Programs, click Add New Programs.
2. Click Browse, and navigate to the SigPlus.exe.
3. Run the install through the Add/Remove Programs wizard.
4. Choose your tablet model during install and the COM1 connection type.

If using Server 2008/2012. Remote Desktop Session Host Configuration must be installed for this to work. See checking port settings below.
1. From a CMD line, type Change user/install to enter Install mode.
2. Install SigPlus.exe. Choose your tablet model during install and the COM1 connection type.
3. After installation, from CMD line, type Change user/execute or restart server to place server back into Execute mode before using the application.

Create a SigPlusRoot.ini file and change the TabletComPort.
1. Copy SigPlus.ini from C:\Windows and paste it into the root directory (e.g. C:).
2. Rename it SigPlusRoot.ini.
3. Change the TabletComPort assignment to the desired COM port (see step 7 in Part 1 below).

**Workstation Setup**

Below are the steps for Terminal Servers from the manual (08/20/2015).

Part 1: Client Side Installation
1. Download and save the SigPlus BSB Pad Installer (.exe) to your local client computer/terminal.
2. Right-click the sigplusbsb.exe and choose Run as Administrator.
3. Follow the installer, choosing the appropriate tablet model.
4. Click Start, right-click Computer, click Properties.
5. Click Device Manager from the menu on the left.
6. Click the white arrow to expand the Ports section and locate the USB Serial Port.
7. Note what COM port was assigned to this device. In this example, the port is COM9.

Part 2: Setting up Remote Desktop for Serial Port Redirection
1. Click Start, All Programs, Accessories, Remote Desktop Connection.
2. The Remote Desktop Connection opens. Click Options in the corner.
3. Click the Local Resources tab at the top of the window. Click More in the Local Devices and Resources section of the window.
4. Click Ports to check the box.
Part 3: Setting Up Signature Capture for Each User
1. Log into the server via an RDC session, and download and save the winloc.exe utility: www.topazsystems.com/Software/winloc.exe
2. Double-click the winloc.exe to run.
3. Click on WINDOWS from the list and note the Path reported.
4. Copy the SigPlus.ini file from C:\Windows and paste it into the path reported by winloc.exe.
5. Double-click this new SigPlus.ini file to open.
6. Change the TabletComPort assignment to the COM port you noted from step 5 on page 6.
7. Once done, click File, Save.
8. You will need to repeat this process for each user that has a signature pad. Be sure to log in as the particular user you wish to set up each time.

Part 4: Test Your BSB Signature Pad
Before testing your application, you should test with DemoOCX.exe. This can be found in C:\Windows\SigPlus on the server. Open DemoOCX.exe, click Start, and sign on your pad. You should see your writing in the demo window.

Installation Files
Client Side
http://www.topazsystems.com/software/sigplusbsb.exe (run as Admin)

Host Side (through RDC)
http://www.topazsystems.com/software/sigplus.exe (run as Admin)

Notes/Things to Check
- If previous version of SigPlus is installed it is easier to just uninstall and start fresh the first time.
- Make sure you enable ports in the RDC options. To check, follow the steps below for Checking Port Settings.
- You may need to double check that ports are allowed on RDC sessions. To check, follow the steps below for Checking Port Settings.
• Make sure the SigPlus.ini files is in C:\Windows
• Make sure to edit the SigPlus.ini file and put in the correct port number.

Checking Port Settings
Client Side
1. Open RDC.
2. Click Options, Local Resources tab, More.
3. Make sure Ports is checked.

Host Side (through RDC)
1. Click Start, type Remote Desktop Session Host Configuration into search, click to open.
2. Right-click the RDP-TCP Connection and go to its properties.

Connections

<table>
<thead>
<tr>
<th>Connection Name</th>
<th>Connection Type</th>
<th>Transport</th>
<th>Encryption</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>RDP-Tcp</td>
<td>RDP 7.1</td>
<td>tcp</td>
<td>Client Compatible</td>
<td></td>
</tr>
</tbody>
</table>

3. Click Client Settings.
4. Make sure COM Port is not checked.

Questions and Answers
Topaz signature pad is not writing properly after setup.
Sometimes the test application locks the signature pad. Unplug then re-plug the topaz signature pad to fix the issue.

Unable to sign using a Topaz signature pad when running Open Dental as an administrator.
Do not run Open Dental as an administrator.

Topaz HSB Model Setup
The Topaz HID USB (HSB) signature pad is our recommended Topaz model for simple Electronic Signatures(306) pad integration. HSB models require fewer permissions than BSB.

First time HSB Topaz pad users will need to install software drivers for their model. See SigPlus Pro website to select your model and download drivers.

Local Use: Use the SigPlus Installation. It will not always be the case that plug and play will work, as it is up to Windows to install the driver and recognize the device automatically. The How-To Guide steps (below) might not be necessary for local use.

Client/Server installation: The SigSock HSB Pad How-to-Guide (PDF) covers the following topics.
• Overview
• Setting up SigSock (Client-Side)
• Setting up SigSock (Server-Side)
• Using SigSock

The How-To Guide is subject to change and is owned by Topaz Systems Inc.

Note: For remote desktop users, If you are going to turn on the Terminal Services role on your remote desktop server, HSB models will not work. The HSB model is not recommended for Terminal Services, although it will work with single remote desktop sessions when the Terminal Services role is turned off. Use the Topaz BSB Model Setup(308) instead.
Supernumerary Teeth

Patients with supernumerary teeth can have procedures charted and sent to insurance using the process below.

1. Chart procedure as normal.
2. On the Procedure(303), change the tooth number.
   - For supernumerary teeth, valid values are 51-82 and AS-TS.
   - Permanent supernumerary tooth numbers add 50 to the tooth number (tooth 1 = 51).
   - Primary supernumerary tooth numbers add an S (tooth A = AS).
3. Click OK and send procedure to insurance.

Procedures for supernumerary teeth do not show on the graphical tooth chart, but they do get billed to insurance. To show a supernumerary tooth on the graphical tooth chart use the Draw(332) tool to draw in a tooth.

Procedure - Financial Tab

In a Procedure(303), at the bottom, is the Financial tab.

This tab shows insurance estimates and payments, patient payments, attached adjustments, and any procedure discounts.

Insurance Estimates and Payments

Each entry row is a Claim Procedure(221). Estimates are usually automatic based on the Insurance Plan(81). If an estimate doesn't look right or is missing, first make sure the insurance plan is set up correctly.

- Each procedure can have only one estimate per insurance plan.
- The status column indicates the status of the claim. Est indicates estimates that are not yet attached to a claim.
- If you create a Treatment Plan(283) before entering the insurance plan, you may need to update fees to affect estimates. See Fees Update(1218).

If the insurance plan is correct but you still need to make a change, there are some situations where you can manually edit an estimate.

- **Override the estimate:** Maybe you got a pretreatment estimate back from insurance or you have a fee schedule to follow. Double click on the estimate row, then enter a different amount for Insurance Estimate. You can also override percentages, allowed amounts, copays, etc.
- **Do Not Bill to Ins:** Check when you do not want to send the procedure to insurance. If, on the Procedure Code(1200), this procedure is set up as Do Not Usually Bill to Ins, the box will be checked by default.
To manually add an estimate:

1. Click **Add Estimate**.

2. Select the insurance plan, then click OK to open the **Edit Claim Procedure Window** (221). Enter the estimate information and click OK.

Adding an estimate to a procedure on an insurance plan that already has an estimate will open the existing estimate.

**Patient Payments**

Payment splits in **Patient Payments** (158) that are attached to this procedure will list. Double click to edit.

Procedures with paysplits attached cannot have their status changed from *completed* unless the total of paysplits attached equals zero.

**Adjustments**

Adjustments can be only added to completed procedures.

- **Add New Adj**: Create a new adjustment.
- **Link Existing Adj**: Attach an existing adjustment to this procedure. A list of all unattached adjustments in the patient’s account will list. Select an adjustment then click OK.
To edit an adjustment, double click it.

**Procedure Discounts**

TP Procedure Discount (292) applied at the treatment plan level show, or a specific dollar amount can also be entered. When the procedure is set complete, discounts will show as adjustments.

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**Procedure - Medical Tab**

In the Procedure (303) Edit window, the Medical tab may show.

The Medical tab appears if Medical Insurance (128) is turned on in Show Features (806). Enter information on this tab if you intend to send a medical claim or if insurance requires that you attach ICD-10 diagnosis codes to a procedure.

**Medical Code:** The corresponding medical code for this procedure. If you set a default medical code on the Procedure Code (1200), it will automatically show. This is required when sending a medical e-claim.

**Mods:** Medical code modifiers.

**Unit Quantity:** The quantity refers to the type. E.g. 5 (unit quantity) minutes of anesthesia (unit type). Your procedure fee will be multiplied by the unit quantity.

**Unit Type:** Type of quantity. Options are:
- MultProcs
Revenue Code: If you set a Default Revenue Code for the procedure code, it automatically shows here.

Drug NDC: The National Drug Code. If you set a default value for the procedure code, it automatically shows here.

Drug Unit/Drug Qty: The quantity refers to the unit. E.g. 5 (drug quantity) milligrams (drug unit).

SNOMED CT Body Site: Only visible if EHR is turned on. Click [...] to select SNOMED CT Codes (727) that references an anatomical site. Click None to clear the box.

Princ Diag: Indicates that Diagnosis Code 1 is a Principal Diagnosys. At least one procedure for each visit needs to have this box checked.

Use ICD-10 Diagnosis Codes (uncheck for ICD-9): Affects this procedure only. Check the box to use ICD-10 codes; uncheck to use ICD-9 codes. Set the default setting in Chart Module Preferences (706).

ICD-9/ICD-10 Diagnosis Code 1 - 4: Enter a diagnosis code manually, or click [...] to select up to four codes from a Diagnosis Code pick list. To set a default diagnosis code for new procedures, see Chart Module Preferences. To clear a code, click None. See ICD-10 Codes (129).

Ordering Provider Override: Set an ordering provider for this procedure on the claim. This provider will override any other provider selected elsewhere. By default, there is no override and the treating provider is used. See E-Claims Complexities (496), Ordering Provider, for the logic.

- Internal: Select a provider from the Providers (1252).
- Referral: Select a provider from the Referral List (1268).
- None: Clear the override.

Procedure - Misc Tab

In the Procedure (303), at the bottom, click Misc.

The Misc tab shows options for Medicaid and Public Health (71).

Billing Type 1/2: Only visible when Medicaid is turned on in Show Features (806). Billing types can be manually set per procedure in order to flag procedures for inclusion in custom reports.

Prognosis: Prognosis is not used by most offices, although it may be required in some states. If it is required to show on
the treatment plan, then use Display Fields(900) to add a prognosis column to the Treatment Plan Module(283) main grid. To speed entry, prognosis can be set when entering treatment. Customize options in Definitions: Prognosis(885).

**Site:** Only visible if Public Health is turned on. Click [...] to select the site where the procedure was done. This site determines the default place of service set on the Edit Claim - General Tab(213). See Site List(1272).

**Place of Service:** Only visible if Public Health is turned on in Show Features. Defaults to the Default Proc Place of Service for the practice when creating a new procedure or completing a procedure. Click the dropdown to change.

**Clinics:** If an appointment has a clinic assigned, when its procedures are set complete (by setting the appointment complete or the individual procedure complete) the clinic Default Proc Place of Service will override the practice Default Proc Place of Service. The practice default will be used if the procedure is not attached to an appointment, or is set complete any other way.

**Billing Note:** Shows on Statement(269).

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**Procedure Notes**

Procedure notes are daily treatment notes that are stored with the procedure.

In the Procedure(303) Edit window, at the right, is the Procedure Note area.

They can include anything that normally goes into your chart notes, such as materials used, procedures followed, treatment performed, anesthetic, informed consent, etc. Procedure notes support Electronic Signatures(306).

**Hints**

**Default Notes:** To simplify data entry of procedure notes, set up default notes for Procedure Codes(1195) that automatically copy into a procedure when it is added to a patient's chart. Default notes can be set up for treatment planned and/or completed procedures.

- Completed Note: A note that automatically copies into the procedure note when the procedure is set complete.
- TP'd Note: The note that automatically copies into the procedure note when the procedure has a status of treatment planned.

**Incomplete Notes:** Use two quotes "" in a note to remind staff to enter specific information in a note (Example: Due Date ""). If the information is not completed within the procedure, a red Incomplete Note warning will appear above the note. To view a list of completed procedures with incomplete notes, see Incomplete Procedure Notes Report(1300). Other examples: composite shade, crown shade, denture shade, due date, blood pressure, nitrous levels, etc.
**Auto Notes**: Insert Auto Notes(317) in procedure notes to prompt staff to enter information. In Chart Module Preferences(706), check Procedures Prompt for Auto Note. Then, opening the Procedure Info window will trigger any unanswered auto note prompts.

**Note Edits**: By default, when a procedure note is edited by two or more users at the same time, the note saved last will show in the chart. To merge notes together instead, change the setting for Procedure notes merge together when concurrency issues occur in the Chart Module preferences.

**Procedure Group Notes**: Create one Procedure Group Note(479) for multiple procedures instead of attaching notes to individual procedures.

For other note options, see Notes(320).

**Security** All completed procedure notes are automatically and permanently stored in the database. Every change (editing or deleting a note) is recorded, and an archived note history can be viewed in the Chart Module(298) under Show tab, Audit. The archived history of completed procedure notes is not editable and cannot be deleted.

**Permission-based Locking**: There are several user Permissions(1118) that affect access to procedure notes.
- Create Completed Procedure (or set complete)
- Edit Completed Procedure (full)
- Edit Completed Procedure (limited)
- Edit EO or EC Procedures
- Show Procedure Fee
- TP Procedure Delete
- Procedure Note (full)
- Procedure Note (same user)
- Group Note Edit (other users, signed)

**Procedure Lock**(1416): Lock procedures, only allowing notes to be appended. This is not used by most offices.

**Examples**
Below are some examples that show the difference between default procedure note templates and auto notes.

**Strategy 1: Fill in the blank default note**

**Strategy 2: Pre-filled default note**

**Strategy 3: Auto note**
Comprehensive Exam Medications: (pick from list) Allergies: (pick from list) Medical Conditions: (pick from list) PSR:222222 Overall PSR:2 Soft Tissue Screening: (pick from list) Dental Exam: No caries. Treatment plan printed. Pt Concerns: None PARQ.

**Auto Notes**
Place cursor in a Procedure(303) Note box. Above the box, click the Auto Note button.
The Auto Note button is also available in Commlogs (1654), and Tasks (1695).

Auto notes are templates used to insert frequently entered, large Notes (320) (e.g., for hygiene, root canals, materials, anesthetic, post op instructions). In addition to static text, prompts can offer a selection of responses or the ability to enter text. To create or edit auto note templates, see Auto Note Setup (822).

Note: Auto notes can be easier if you prefer to use one note for an entire visit rather than a separate procedure note for each procedure. In addition to the normal procedures for the day, there will be a clinical note, which is just a procedure with a code that is not an ADA code. For example, Zclin. Leave the default notes blank, and use auto notes to compose a single clinical note.

When auto notes are supported in a text box, an Auto Note button will appear above or below the text box.

Auto notes can be grouped by category (folder). Click + to expand a folder tree. Auto notes have a paper icon.

Double click the auto note to insert. The text of the note will show on the right. Any prompts in the auto note will display in sequence.

For each prompt, select the response or enter text.

- **Back**: Move back one prompt to change or view a response.
- **Preview**: View a preview of the response as it will look in the completed auto note.
- **Remove Prompt**: Remove this prompt from the auto note completely.
- **Next**: Move on to the next prompt. If current prompt is left blank, the prompt will remain in the auto note so edits can be made later.
Once all prompts have a response, the Compose Auto Note window will remain open with the full text of the note on the right.
- To insert another auto note, repeat steps 2-3.
- Edit or add text as desired.

**Editing Auto Note in Progress**
Prompts left unanswered can be answered later on. Simply return to the note and select the **Edit Auto Note** button. The auto note will resume at the prompt where it was initially skipped. Button will appear on Procedure Notes, Commlogs and Tasks when available.

**Right Click Text Box**
In **Procedure Notes** (303), or certain other text boxes, right-click.

These text boxes support **Quick Paste Notes** (1088) and **Spell Check** (1191).

Below is a list of textboxes with right click options and their type. This table has been ommitted.

**Inserting Dates**
There are several ways to quickly insert today’s date in a right click text box.
- In the text box, press CTRL + D.
- Right click in the text box, then click Insert Date.
- Click Date at the bottom of the quick paste notes window.
Notes
There are many different places for notes in Open Dental. This page describes which notes should be used for which purposes and protocols your office should use in organizing your notes.

Webinar: Clinical Charting II: Clinical Notes.

Notes used with Procedures

- **Procedure Notes** (316): Use Procedure (303) notes in the Chart Module (298) to document anything that normally goes into your chart notes, such as materials used, procedures followed, treatment performed, anesthetic, informed consent, etc. You can optionally set up default Procedure notes (Procedure Code (1200)) that copy automatically into a procedure every time a procedure is treatment planned or set complete. Then only very minor changes usually need to be made. All procedure notes are automatically saved, changes are recorded, and all actions are archived and viewable in the Chart module under Show tab, Audit.

- **Chart Module Progress Notes**: The Chart Module’s lower right grid shows the current chart view which filters which notes are displayed. Right clicking into the Chart Module’s lower right grid allows printing the current displayed notes. Create additional chart views to display different progress notes filters from Show Chart Views (328).

- **Clinical Note**: Some other dental software products have a clinical note, a daily note, or a procedure note. In Open Dental, those are all just ordinary procedures that use a dummy procedure code. We include clinical note and procedure note as preconfigured procedure codes for you to pick from. These are typically set up as Procedure Buttons (736) for faster entry.

- **Procedure Group Note** (479): A single clinical note attached to multiple procedures by the same provider.

- **Auto Notes** (317): Templates used to insert frequently entered, large notes (e.g. for hygiene, root canals, materials, anesthetic, post op instructions). They can contain prompts and prefilled text.

General Purpose Notes

- **Quick Paste Notes Setup** (1088): Used to organize and enter frequently used notes by using templates. It is similar to Procedure Notes, but covers many different kinds of notes. Also lets you insert dates.

- **Commlog** (1654): Commlogs are for non-clinical patient communication. This includes email, patient and referral letters, phone calls, insurance calls, etc.

- **Medical/Service Notes**: The Medical (466) has a place for Med Urgent, Medical Summary, and Service Notes. The Med Urgent note can be set to show on appointments. See Appointment Views (7).

- **Tooth Chart Notes**: In the Chart module under the tooth chart, there is a text box for notes.

Financial Notes

- **Family Urgent Fin Note**: Important financial notes can be entered as a Family Urgent Fin Note at the top of the Account Module (150). This note shows in red and applies to all family members. Any changes affect all family members. The note displays when you hover over an appointment and on the Patient Appointments (24) window.

- **Family Financial notes**

Appointment Module Notes

Sometimes you want notes to show in the Appointments Module (1) schedule that are not part of appointments or procedures.

- **Patient-specific notes**: Patient notes can act as reminders to call a patient at a specific time, to run recurring credit card payments, to follow up on phone calls, or to call patients who request to be called if a patient cancels. Simply create an appointment with a note and no procedures.
  1. In the Appointments module, click View Pat Appts.
  2. Click NOTE for Patient.
  3. Enter the note in the Patient NOTE field on the left.
  4. Click OK to send the note to the pinboard, then drag the note to the schedule.
  5. Once the note has been handled, set it complete, or delete it.
Set patient note color in Definitions: Appointment Colors(843). This overrides provider and appointment type color and will change when the note is set complete.

**General Notes:** General notes that are not attached to a patient can also show in the Appointments module. For example, add notes about office schedule changes, staff out, holidays, meetings, notes to staff, etc.
1. Create a new patient called Miscellaneous, Notes or something similar. Remember that the displayed format will be Last Name, First Name.
2. Select the note patient, then schedule an appointment. On the Edit Appointment(20), enter the note in the Appointment Note field.

To customize the general note's color, create an alternate provider for the note (e.g. NOTE) and set the provider's color to something that makes sense in your office. Then select the NOTE provider on the Edit Appointment window for the note.

**Blockouts(10):** Blocks of time on the appointment schedule that designate specific purposes.

**Address and Phone Notes**
Enter these notes on the Edit Patient Information(62). Make notes about when to call a patient, which number the patient prefers, extra phone numbers, extensions, bad phone numbers, bad addresses, alternate addresses, etc. Text will show in bold red in the Patient Information area of the Family module. These notes also show in the Unscheduled list, Recall list, and appointment.

**Schedules**
Notes that show on printed schedules (e.g. holidays, practice notes) can be entered in Schedule Setup(1099).

**Treatment Plan**
Customize the note that shows on printed Treatment Plans. Treatment Plan Module Preferences(703)

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**Procedure over Multiple Appointments**

See Enter Treatment(301).

For crowns, bridges, dentures, partials, etc, there is usually a prep or impression appointment and then a seat or deliver appointment. The fee is either charged at the first appointment or the last appointment. Decide which method to use before setting up your procedure codes in the Procedure Codes(1195).

**Fees**

**Fee due at first appointment**

A more effective way to ensure the practice collects the money for the procedure. The responsibility falls on the patient to follow up and make sure the crown gets seated, etc. The patient is charged whether or not they return.

Note: Some insurance companies prefer the procedure to be billed on the prep date, though many do request to be billed on the seat date. The insurance company may have a clause that the coverage date of the patient may only apply to the seat date.

1. Schedule the first appointment. For the procedure use the standard ADA code with the proper fee attached. Your default Procedure Notes(316) would be notes for the prep or impression. Example: 3 carps 2% Lido-1:100k epi, prep, cord with hemostat, PVS, etc. -or- Alginate impression, opposing alginate, shade 102, etc.
2. For the second appointment, use a special no-fee procedure code that is marked do not bill insurance and has a fee of $0. The code should not look like an ADA code (e.g. use a beginning N instead of the usual D to indicate no-fee). The procedure might be Crown Seat or Denture Deliver. The procedure note would be your standard note for seating or delivering. Example: Removed temp, checked contacts and bite, showed to patient, cemented Fuji. -or- Delivered. Checked fit, bite, appearance, etc.
Fee due at the second or last appointment

This method tends to more closely follow most insurance company policies. If the patient does not return for their second appointment, follow up and charge the patient for the lab fee they incurred.

1. Schedule the first appointment using the no-fee procedure code that is not billed to insurance such as Crown Prep or Denture Imp, with the appropriate procedure notes (see above).
2. For the second appointment, use the standard ADA code that is billed to insurance.

In Process Procedure Status

Procedures that occur over multiple appointments can be grouped together to ensure claims are sent at the correct time.

There are two ways to do this:

1. From the Chart Module (298), highlight all procedures, then right-click and select Group for Multiple Visits.
2. Set up Procedure Buttons (736) to automatically group for multiple visits.

When one of the grouped procedures is set complete, it will display with a status of Complete (In Process) in the Procedure (303) Info window and Account Module (150). Once all procedures in the group have been set complete, the In Process status will be removed.

Claims cannot be created until all procedures in the group have been completed.
Missing Teeth
In the Chart Module, click the Missing Teeth tab.

Missing or hidden teeth are recorded at the patient's first visit, before entering treatment. This information is required when submitting claims and allows proper selection of pontics for bridges. Teeth marked as missing do not show on the Graphical Tooth Chart and are marked skipped when you create the first perio chart.

When selecting teeth, click on one or more teeth in the tooth chart. Click and drag to quickly highlight multiple teeth.

There are five options when selecting teeth:
- **Missing**: Mark a selected tooth as missing. The tooth number will still show on the tooth chart, but the tooth will not. Procedure codes that have a paint type of Extraction are automatically marked as missing when the procedure is set complete or entered with a status of EO or EC. Deleting the procedure does not make the teeth reappear; you must manually set the teeth not missing.
- **Not Missing**: Return a missing tooth to the chart.
- **Edentulous**: Mark all teeth as missing at once.
- **Hidden**: Remove the selected tooth and tooth number, from the chart so there is no way to select it for procedures. This is commonly used when a premolar has been extracted and the teeth have been moved by orthodontics to close the space. To quickly hide four premolars at once:
  1. Highlight all four.
  2. Click Hidden.
  3. Click and drag to highlight all the teeth posterior to the hidden premolars.
  4. Click the Movements tab, then click the Mesial + button 3 times to close all the spaces. Select a hidden tooth, then unhide it.
- **Unhide**: Select a hidden tooth, then unhide it.

Tooth Movements
On the graphical tooth chart you can shift, rotate, and tip teeth to document a patient's current dentition.

In the Chart Module, click the Movements tab.
Click on one or more teeth in the tooth chart. Click and drag to quickly highlight multiple teeth.

Select or enter the desired movement in each box. If the value is typed in, click Apply. If one of the six boxes is blank, then not all selected teeth have the same value.

- **Shift millimeters**: Click -/+ to decrease or increase the Mesial, Occlusal, or Labial value by 2. To indicate a tooth is present but not erupted, enter a negative occlusal value until the tooth is grayed out (at least -12).

- **Rotate/Tip degrees**:
  - Rotate: Click -/+ to decrease the value by 20.
  - Mesial/Labial Tip: Enter a value, or click -/+ to decrease the value by 10.

When you are done, click on the teeth to deselect them. It does not happen automatically.

Click **Clear All** to return all movement values to zero.

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**Primary / Permanent Teeth**

In the **Chart Module** (298), click the Primary tab.

By default, the **Graphical Tooth Chart** (464) shows permanent teeth. However, you can set teeth as primary or as mixed dentition.

The above image shows a combination of permanent and primary teeth.
Select the option that best fits the patient:
- Click a specific tooth or teeth, then mark it as **Primary** or **Permanent**. Click and drag to quickly highlight multiple teeth.
- Set all teeth at once.
  - **Set All Primary**: Mark all teeth currently on the tooth chart as primary.
  - **Set All Permanent**: Mark all teeth currently on the tooth chart as permanent.
  - **Set Mixed Dentition**: Change the tooth chart to show a combination of primary and permanent teeth (8 - 12 year olds).

**Tips for unique situations**
Show movements on the unerupted permanent tooth:
1. Enter the tooth movement.
2. Mark tooth as primary.

Show congenitally missing permanent tooth:
1. Mark tooth as missing.
2. Mark tooth as primary.
3. If the primary tooth is also missing, mark it as missing as well.

Show permanent molars as unerupted: Mark them as primary.

**Planned Appointments**
In the Chart Module(298), click the Planned Appts tab.

Planned appointments are a way to track a patient's next appointment for treatment planned procedures (e.g. RCT, crowns, fillings) from the Chart Module(298). All patients should have either a planned appointment or be marked Done before going to the front desk. This ensures that no patients get dropped and helps the front desk quickly process the patient with minimal effort. To track unscheduled planned appointments, use the Planned Appointment Tracker(39).

Typical workflow:
1. While the patient is in the chair, the assistant or provider enters the treatment planned procedures in the chart (procedures, additional time, notes).
2. The assistant or provider creates a planned appointment for the next appointment, attaching the treatment planned procedures.
3. The patient goes to the front desk to schedule. The front desk sees the planned appointment in the Appointments for Patient window, copies it to the Pinboard and schedules the next appointment.
4. Patient comes in for next appointment. The provider verifies that planned procedures match what is scheduled.
5. When the planned treatment is finished, the provider or assistant sets the appointment complete (this also designates the planned appointment as complete but does not delete it).
6. If more treatment is needed, enter another planned appointment.
7. If there is no planned treatment, mark Done. This will delete all planned appointments and indicate to the front desk that there is no planned appointment (Planned Appt Done will be checked on the Patient Appointments (24) window).

- Note: Creating more than one planned appointment is allowed, but because plans change, it is often more efficient to only enter planned appointments that are ready to be scheduled. If you do enter multiple planned appointments, it can be hard to accurately predict the procedures, and thus you may need to frequently revise the planned appointments if procedures change. We recommend using Treatment Plans to outline a course of treatment while using planned appointments to communicate which appointments are ready to schedule.
- Hygiene appointments (e.g. cleanings) should not be entered as planned appointments. Instead use the Recall List (27).
- If you do not have computers in the operatories, planned appointments can be ignored. Instead schedule the next appointment using your standard procedure as a guideline.

**Entering a Planned Appointment**

Note: To prompt users to create a planned appointment for procedures that are treatment planned today, see the Chart Module Preferences (706) for Prompt for Planned Appointment.

Enter the treatment planned procedures that will be attached to the planned appointment. See Enter Treatment (301).

Planned appointments that already exist are listed.
- By default, planned appointments that are associated with completed appointments are also designated complete and hidden. To show them, check Show Completed. The setting of this checkbox returns to unchecked each time you restart Open Dental.
- To reorder planned appointments, use the up/down arrows.
- To edit a planned appointment, double click it.
- Background color and text color of entries is determined by settings in Definitions: Prog Note Colors (884).

Click Add. The Edit Appointment (20) will show and the treatment planned procedures will list under Procedures on this Appointment.

Highlight the procedures to attach to the planned appointment.

If you need to attach Lab Cases (379), click Lab in the right panel. Select the lab case or if needed create it. When the planned appointment is scheduled, the lab case will also be attached.

From the Treatment Plan Module (283):
1. Highlight the needed treatment planned procedures.
2. Click + Plan Appt. The Edit Appointment Window will open and the selected treatment planned procedures will show under Procedures on this Appointment.
3. If you need to attach Dental Lab Cases, click Lab in the right panel. Select the lab case or if needed create it. When the planned appointment is scheduled, the lab case will also be attached.
4. Click OK.

The planned appointment is now ready for the front desk to schedule. To schedule the appointment chairside instead, click Pinboard on the Planned Appts tab, then drag it to the schedule. This is useful when providers schedule their own appointments.

**When treatment is complete**: The planned appointment should exist until scheduled treatment is complete so that cancellations or no-shows can be tracked in the Planned Appointment Tracker. Once complete, planned appointments are also marked complete and won't show in the tracker. Deleting planned appointments is optional.
Deleting planned appointments: Deleting planned appointments will permanently remove them, but will not affect any scheduled or completed appointments. To delete all planned appointments, mark Done. This will clear the list and also check the Planned Appt Done box on the Appointments for Patient window. To delete selected planned appointments only, click Delete. This will not affect the Planned Appt Done box.

Scheduling the Planned Appointment
Usually the chairside assistant or provider enters the planned appointment while charting treatment, then sends the patient to the front desk for scheduling.
1. In the Appointments Module, select the patient.
2. Click Make Appt, Make Recall, Fam Recall, or View Pat Appts. The Appointments for Patient window will open. The planned appointment will show in the appointment list just like any other appointment, except has no date or time.

This window lists the patient's planned, scheduled, broken, unscheduled, and completed appointments. Planned appointments already completed do not show by default. To show them, check Show Completed Planned Appts.

Planned Appt Done: This box reflects the value of the Done box in the Chart module, Planned Appt tab. When checked, this notifies scheduling that the next appointment will be a recall, not a restorative procedure. If unchecked, there may be a planned appointment.

3. Highlight the planned appointment to schedule.
4. Click Copy to Pinboard.
5. Drag the appointment to the schedule.

The new scheduled appointment will duplicate the procedures and length of the planned appointment. The planned appointment itself remains in the Appointments for Patient list until its scheduled appointment is marked complete, or until it is deleted from the Planned Appt tab in the Chart module. In the Chart module Progress Notes, scheduled appointment and associated planned appointment always show next to each other regardless of date.
If a patient leaves the office without making an appointment, or if they cancel at a later date, use the Planned Appointment Tracker to track and schedule planned treatment.

**Scheduling chairside:** To schedule the appointment chairside instead, click Pinboard on the Planned Appts tab, then drag it to the schedule. This is useful when providers schedule their own appointments.

**Changes to a planned appointment:** Usually planned appointments are not changed by front staff. Instead, the chairside assistant or provider should review, discuss, and verify the next steps with the patient, making changes as needed. To edit it from this window, double click it.

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### Show Chart Views

In the **Chart Module** module, click Show tab.

![Show Chart Views](chart_views.png)

Use the Show Tab to set up different views for the grid in the lower right of the Chart module (often called the Progress Notes) and define what information shows in each view. Some selections also affect what shows in the **Graphical Tooth Chart**.

Items that are checked show in the current view. Check or uncheck an item to change the view. Changing an item here does not permanently change view settings.

**Procedures:** Show certain procedure statuses. This also affects what shows on the graphical tooth chart.
- Treat Plan: Procedures with a TP status.
- Completed: Procedures with a C status.
- Existing: Procedures with a EO or EC status.
- Referred: Procedures with a R status.
- Conditions: Procedures with a Cn status.

**Proc Notes:** Show Procedure Notes with procedures.

**Object Types:** In addition to procedures, show other objects.
- Appointments
- Comm Log entries. Check **Family** to also show comm logs for family members. If Comm Log is unchecked, no comm logs will show.
- Tasks attached to the patient, any family members, or to an appointment. The full path to the task will show.
- Emails sent to the patient.
- Lab Cases (dental).
- Rx (paper or electronic prescriptions).
- Sheets: Forms generated using **Sheets**.
**All / None**: Click All to select procedure status options and object types. Click None to clear all selections. Does not affect the *Is TP View* setting.

**Date Filter**: Indicates the date range of items that are showing. Click [...] to change the date range.

![Progress Notes Date Range](image)

Note: With a date range defined, right-click and select Print Progress Notes to print notes in that date range.

**Search**: Find progress note items that match search terms. This will search through all showing Object Types. Any item matching your search term will display.

**Selected Teeth**: Show only procedures and progress notes for teeth selected in the graphical tooth chart. Selecting this box deselects other object type boxes.

**Audit**: Switch to Audit mode to include deleted procedures (status of D) and deleted sheets in the view. Procedures can't be edited in Audit mode. Deleted sheets can be restored by double clicking to open the Fill Sheet window, then clicking Restore.

**Is TP View**: Adds a Treatment Plan check box to the *Enter Treatment* (301) tab. The Treatment Plan check box allows you to view and create treatment plans from the Chart module. See Treatment Plan in Chart (462). Checked by default when you create a new view. It is also checked in existing views if you update and no existing views have the box checked.

**Chart Views**: A list of all chart views currently set up. When you highlight a Chart View, the grid switches and the view's default options show on the left. These values can be changed without affecting the default view settings. If you do change an option, Custom View will show under the date.

Open Dental comes with a Default View set up. We recommend you rename it Progress Notes or create a new view called Progress Notes. You can also create other views that show or hide specific information. The view listed first is the default view every time you start Open Dental. Switch between views using the function keys (F1-F12) on your keyboard or by clicking on a row. Use the Up/Down arrows to reorder views.

**Add or Edit a Chart View**
1. Double-click a chart view to edit or click Add to create a new view.
2. **Description**: Enter the name of the view. This will also show as the grid title.

3. **Dates Showing**: Select the date range of items that will show. Options are All, Today, Yesterday, This Year, Last Year.

4. Select the Procedure statuses, Object Types, and other options to show in the view. These will be the default values but many can also be changed on the main Show tab without permanently affecting the view settings. Click **All** to quickly select all boxes, or **None** to quickly clear all boxes.

5. Define which columns of information will show for each item. To move a field to/from Fields Showing and Available Fields, highlight it, then click the right or left arrow.
   - **Fields Showing** lists the columns currently in the view, in the order each column will show (from left to right).
   - **Available Fields** lists all columns that can be added to the view but currently are not.

Note: In non-U.S. countries, the internal name for the ADA Code field is Proc Code.

To edit a Fields Showing column header or width, double-click it, enter the information, then click OK.
New Description: The column header.

Column width: Enter any number equal to or greater than the Minimum Width. The minimum width is based on the number of characters in this field. When using Chart Layout (460), set as zero to fill the available space.

6. Click OK on the Chart View Edit window to save the view.

Some Field Names are not self explanatory. Below are brief descriptions.

- **Date**: In most cases, the date the item was created. Appointments show the date the appointment takes place.
- **Time**: Varies by object. Emails show exact time it was created. Appointments show the scheduled time. This option will not show procedure times.
- **Th**: Tooth Number.
- **Surf**: Tooth Surface.
- **Dx**: Diagnosis.
- **Description**: Description of the appointment, procedure, etc.
- **Stat**: Procedure status.
- **Prov**: The attached provider.
- **Amount**: The procedure's billable fee.
- **User**: The user logged on to Open Dental when the item was entered.
- **Proc Code**: The procedure code.
- **User**: If a procedure, lists the user who last created or edited the procedure’s notes. If an email, lists the user logged-on when the email was sent.
- **Signed**: Indicates when an item (e.g. consent form, procedure) has been electronically or digitally signed.
- **Priority**: The procedure's priority level.
- **Date TP**: Day the procedure was added to the treatment plan.
- **Date Entry**: Day the procedure was entered.
- **Prognosis**: The procedure's prognosis.
- **Length**: Appointment length.
- **Abbr**: Procedure code abbreviation.
- **Locked**: Indicates if a procedure has been locked using Procedure Lock (1416).
- **HL7 Sent**: Indicates if a procedure has been sent via HL7.
- **ClinicDesc**: The procedure’s clinic description set in Lists, Clinics.
- **Clinic**: The procedure’s clinic abbreviation set in Lists, Clinics.

**Logic of Row Order in Progress Notes**
The Progress notes is a very complex grid with many different kinds of objects in it. Starting with version 12.0, the following logic is used:

1. All rows sorted by date (but not time).
2. Within each date, rows sorted by type (except, starting in version 12.4, commlogs and sheets are treated as the same type and will be intermingled).
3. Within procedures of same date, sort by status, then priority, then tooth number, and finally procedure code.
4. Other object types that are not procedures (like commlogs, sheets, etc), which have the same date, are further sorted by time.

**Draw on Tooth Chart**

In the [Chart Module](298), click the Draw tab.

Use the Draw tab to draw freehand on the [Graphical Tooth Chart](464). This is useful to indicate items that don't have a graphic (e.g. cracked teeth, abscesses, supernumerary teeth, lingual arch wires, other orthodontic work, etc).

It is possible to draw using the mouse, but takes some practice and a steady hand. It is much faster to draw if you are using a touch screen (e.g. on a tablet). There is no way to hide the drawings, though they can be erased. If the mouse selection is **Pointer**, drawing is not turned on and you can select teeth as usual.

The colors listed are those set in **Definitions: Chart Graphic Colors**(855). The currently selected color shows under the Color Changer option. To choose a color that isn't shown, click **Other** to open the Color window.

**Draw on the Chart**

1. Select **Pen** to turn the mouse pointer into a pen.
2. Click on a color to select it.
3. Click and drag the pen on the tooth chart to draw. Each continuous line is considered one object.

**Erase a Drawing**

1. Select **Eraser** to turn the mouse pointer into an eraser.
2. Click and drag the eraser on an object to erase all of it.

**Change Color of an Existing Drawing**

1. Select **Color Changer**.
2. Select the new color.
3. Single click on an existing line (object) to change its color.
Rx / Prescription

Paper prescriptions can be written and printed in Open Dental.

In the Chart Module(298) toolbar, click New Rx.

Alternatively, in the RX Manage(337)e window, click New Rx.

Setup:
- **Rx / Prescriptions List(1264):** Add new medications to the Prescriptions list. Create templates for common prescriptions and set up drug interaction alerts based on allergies, medications, and/or problems.
- **Rx Layout(1181):** Customize the print layout when printing one prescription on a page.
- **Rx Multiple Layout(1184):** Customize the print layout when printing up to four prescriptions per page.
- **Rx Manage(337):** Create and manage prescriptions and/or print multiple prescriptions per page.

Create a New Prescription

In the Select Prescription window, double-click on a prescription template that is close to your requirements, or click Blank to start with an empty prescription. The Blank button is not available if EHR is turned on.

(Optional) If the prescription list is long, filter the list using the Search.
- **Drug:** Drug name.
- **Disp:** Dispensed amount.
- **Controlled Only:** Check this box to only display prescriptions marked as a controlled substance.

Click Search or press Enter to refresh the list.

Note: If Prescription Alerts(1267) are triggered, a pop up will display the alert message. Click Cancel to select a different prescription template. Click OK to proceed.
Enter or change prescription information as needed.

- **Date**: Defaults to today.
- **Controlled Substance**: Check this box to display the selected provider’s DEA# on the printed prescription. Provider(1255)
- **Is Proc Required**: Check this box to require an associated procedure when printing. Select a procedure from the dropdown. See Procedure Required on Prescription section below for setup.
- **Procedure**: Select the procedure requiring the prescription. Use the dropdown menu to select from completed or treatment planned procedures.
- **Days of Supply**: Required by some states. Enter the number of days this prescription will last. Can be a partial day if needed (e.g. 3.5). Also available as an output text field on Rx / Single Prescription Layout sheets.
- **Drug**: Drug name.
- **Sig**: Instructions for the patient on when and how to take the prescription.
- **Disp**: Dispense number.
- **Refills**: Number of refills allowed.
- **Provider**: Provider filling the prescription.
Note: If the user logged in is associated with a provider, that provider will be automatically selected, and the option locked. If the user is not associated with a provider, select from the drop down menu, or click the button to pick from a list.

- **Dosage Code**: Only visible when EHR is turned on.
- **Notes**: This is only for your use and does not appear on printed prescriptions.
- **Patient Instructions**: Provide instructions to the patient on how the medication should be taken.
- **eRx Pharmacy Info**: Informational field that automatically populates with the pharmacy name when electronic prescriptions are received. This helps verify the correct clinic is selected.
- **Pharmacy**: Click Pick to select a pharmacy from the Pharmacies (1249) if the prescription is called in.
- **Send Status**: Choose the status of the selected prescription. Options include Unsent, InElectQueue, SentElect, Printed, Faxed, CalledIn, GaveScript, Pending.
- **Clinic**: Only shows if Clinics is enabled. Select the associated clinic.

Click **OK** to save without printing.

Click **Print** to save and print it to the default printer for single prescriptions (**Printer Setup** (601)). To print multiple prescriptions on one page, see **Rx Manage** (337).

The Rx sheet set as the default for the Rx sheet type will be used to print single prescriptions. See **Sheet Def Defaults** (1151).

Saved prescriptions will be added to the patient's Progress Notes in the Chart Module and to the patient's medication list. Prescriptions are not previewed before printing, thus they can not be digitally signed or changed before printing. To edit a prescription, double click it then reprint it.

Below is an example of the print layout for the internal Rx sheet (one prescription printed per page). Note that the Generic Substitution Permitted check box in the internal sheet is always checked. To remove the check mark, customize the sheet.

---

**Michael S Haste, DMD**
1462 Commercial St SE
Salem, OR 97302
(503)363-5432
10/04/2006
DEA#: HG4564

---

**Jason L Spander**
DOB: 05/18/1958
(503)745-1240
2240 Applewood Dr N
Salem, OR 97306

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**Rx**
**Pen VK 500 mg**
Disp: 40
Sig: Take 2 tabs ASAP, then 1 tab 4 times a day.
Refills: 0

☐ Dispense as Written
☒ Generic Substitution Permitted

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Signature of Prescriber

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For preprinted forms, we recommend FormSource to have good service and reliability. See their [Open Dental Health Care Form Price List](https://www.opendentalhealthcare.com/forms). See also [Vendors: Printing](https://www.opendentalhealthcare.com/vendors/printing).

**Patient Instructions**
Some offices may want to provide the patient with instructions separate from the prescription.
In the Edit Rx window, enter the instructions in the Patient Instructions field, and Click **Pat Instr.** to print.

---

**Procedure Required on Prescription**

Some states require an associated procedure show on their printed prescriptions. Each of the following steps must be completed to activate the preference.

1. Enable the preference behavior. This preference is disabled by default.
   1. Click Lists, Prescriptions.
   2. Check **Procedure code required on some prescriptions** to enable the subsequent preferences.

2. Enable the preference for each Clinic.
   1. In the main menu, click Lists, Clinics, then double click to open the Clinic (1224).
   2. **Proc code required on Rx from this clinic** to enable the preference on the clinic level.

3. Enable the preference for each Rx template. This will check the **Is Proc Required** preference automatically in the Edit Rx window each time the drug is prescribed.
   1. In the main menu, click Lists, Prescriptions.
   2. Double-click the prescription to open the Edit Rx Template window.
   3. Check **Is Proc Required** for this drug.

4. Enable the preference for an individual Rx.
   1. In the Chart module, click New Rx.
   2. Check **Is Proc Required** if it is not already enabled at the template level.

Select a procedure from the dropdown, enter Days of Supply, and click Print.

See Automation (819) for options available when creating a prescription.

---

**Audit Trail**

Any time a prescription is created, edited, deleted, or printed, a log is created in the audit trail. Users must have the **RxCreate** security permission to create new prescriptions and the **RxEdit** permission to change or delete prescriptions.

To view an audit trail of changes made to a selected prescription only, double click an existing prescription in the Progress Notes, then click Audit Trail on the Edit Rx window.
Rx Manage
Use Rx Manage to prescribe and manage paper prescriptions for the selected patient.

In the Chart Module toolbar, click the New Rx drop down. Select Rx Manage.

Setup:
- Rx / Prescriptions List: Create templates for common prescriptions and set up drug interaction alerts based on allergies, medications, and/or problems.
- Rx Multiple Layout: Customize the print layout when printing multiple prescriptions per page.

All of the patient's prescriptions that already exist will show. To edit a prescription, double click on it.

To add a new prescription, click New Rx. See Rx / Prescription for step by step instructions.

Select the prescriptions you want to print. Click and drag, or press Ctrl while clicking to select multiple.

Click Print Selected. The prescriptions will print to the default printer for RxMulti (see Printer Setup), using the custom RxMulti sheet listed first in Sheet Setup (or the internal sheet if no custom sheet exists). If there are any unused Rx Sheets (e.g. only three prescriptions on a four printout sheet), the unused sheets will be printed with VOID over the top to prevent any editing.

Prescriptions are not previewed before printing, thus they cannot be digitally signed before printing.
Below is an example of the print layout for the internal RxMulti sheet. It can print up to four prescriptions on one page. Note that the Generic Substitution Permitted check box in the internal sheet is always checked. To remove the check mark, customize the sheet.

---

DoseSpot eRx / Prescription

Use DoseSpot to select patients who will receive electronic prescriptions.

In the Chart Module(298), click eRx.
Providers and proxy (non provider) clinicians can begin using DoseSpot to send ePrescriptions after DoseSpot Setup(343) is complete.

For details on using DoseSpot through Mobile Web, see Mobile Web eRx(1542).

Overview: There are six main steps to using DoseSpot. First enable DoseSpot for your providers/proxy clinicians.
1. Select a patient.
2. Add allergies.
3. Add current medications.
4. Add a pharmacy.
5. Prescribe new medications.
6. Subscribe to eRx alerts. See Alert Subscription(1113).

At any point, click Walk Me Through at the bottom of the interface to launch a step by step tutorial walkthrough for all processes in DoseSpot.

Also see the DoseSpot User Guide.

Note: Not all functionality noted in the DoseSpot User Guide is supported by Open Dental.

To launch DoseSpot with a different patient, close the DoseSpot interface, select a new patient in Open Dental, then click eRx in the Chart Module.
- Note: When proxy (non-provider) users select the eRx button, they will need to select the provider they are creating the prescription for from the list. Providers who are scheduled for today will show. If the provider is not scheduled, they can use the "show all" box to see a full list of providers.
- Proxy users can only create pending prescriptions. A registered provider must complete the sending process.

Add Allergies

1. In the Patient Details dashboard, Drug Allergies area, click Add/Edit Drug Allergies. Allergy information already entered for the selected patient shows here.
2. Check No Known Allergies if the patient has no allergies.

3. Fill in the information.
   - **Allergy**: Begin typing the drug name and a list will appear. Select the correct drug from the list.
   - **Status**: Select Active or Inactive. The default is Active.
   - **Reaction Type**: Select Allergy or Adverse Reaction.
   - **Reaction**: Enter the reaction the patient gets from the drug.
   - **Onset**: The date of the first occurrence of the allergy.

4. Click **Save**.

Prescribing a drug the patient is allergic to results in a warning in the Patient Details dashboard.

Add Existing Medications
DoseSpot supports two-way medication syncing. Medications added to DoseSpot automatically list in Open Dental, and medications added in Open Dental automatically list in DoseSpot. Self-reported medications can be edited from both Open Dental and DoseSpot.

By default, all medications added in Open Dental import to DoseSpot as Patient Reported.
1. In the Patient Details dashboard, click **Add Patient Reported**.

2. In the Search field, begin typing the medication name and it will appear. Select the correct medication from the list. If the medication does not appear, manually enter it and click Add.
3. The medication will appear in Medications to Add.
4. Click Save.

Patient reported (or self reported) medications will appear in Medications(470) in Open Dental and in the Patient's Active Medications area as a comment icon in DoseSpot.

Add a Preferred Pharmacy
You must add a pharmacy to the patient before medications can be sent electronically. Preferred pharmacies list under Add/Edit Pharmacies in the Patient Details dashboard.
1. In Patient's Preferred Pharmacies, click Add/Edit Pharmacies.
2. Use the Search By or Specialty dropdowns to filter the pharmacy list, or enter the pharmacy info in the provided fields. Select EPCS in Specialty for EPCS pharmacies.
3. Click Search.
4. Click the preferred pharmacy from the pharmacy list to add it to the patient.
5. To remove a pharmacy, click Add/Edit Pharmacies and select the 'x' next to Pharmacy Name.

Prescribe and Send New Medications
Prescribing New Medications
1. In the Patient Details dashboard, click Add Prescription.
2. In the Search field, begin typing the medication name and it will appear. Select the correct medication from the list.
3. Click the dosage amount listed under the medication.
4. Fill out the following fields:
   - **Effective Date**: This is a required field for controlled substances, and must be within six months of the day the prescription is written.
   - **Patient Directions**
   - **Dispense Amount**
   - **Number of Refills**: Schedule II medications cannot have a refill. Enter zero (0) in that case. Schedule III, IV and V may have five (5) or fewer refills. Non controlled substances may have 99 or fewer refills.
   - **Days Supply**: Cannot exceed 365 days. Schedule II medications require this field and cannot exceed 90 days.
   - Check **No substitutions** if needed.
5. If your state requires it, add ICD/ADA code in the Pharmacy Notes. Click Show Pharmacy Notes below Save Prescription.
6. Click the star icon to save this medication to favorites. Click Save Prescription.

Sending New Medications
1. Scroll down to Pending Medications.
2. Check the box next to the medication to select it.
3. Enter the provider's PIN.
4. Click Approve & Send.

Non controlled substances: Prescriptions are sent immediately and the status is indicated with a gray arrow in the Patient's Active Medications. After refreshing the page, the gray arrow will turn into a green checkmark.

Controlled substances: The prescribing provider must Register for EPCS before sending. See DoseSpot Setup(343). 1. Confirm the pharmacy and prescription.
2. Click Ready to Sign.  
3. Enter the provider's PIN. If needed, select the link to your state's PDMP website. You will need to provide your username and password.  
4. Open the Duo Mobile app on the provider's mobile device and enter the two-factor authentication (TFA) code.  
5. Click Approve & Send.  

The prescription is sent and the status is indicated with a gray arrow in the Patient's Active Medications. After refreshing the page, the grey arrow will turn into a green checkmark.  

**Favorites**  
Favorites are prescriptions that you have already set up and use commonly that can quickly be prescribed for a new patient. Favorites can be edited on an individual basis but will default to the information included when the prescription was favored.  

**Prescribing a Favorite**  
1. In the Patient Details dashboard, click Add Prescription.  
2. Select a drug and dosage amount from the favorites list, or begin typing a drug to narrow down the favorites list.  
3. Verify the sig is correct and click Save Prescription.  
4. Send prescription as normal.  

**Copying the Favorites List**  
The DoseSpot Favorite List is user specific. If you would like a list to be copied to another user, send an email to erx@opendental.com with the user's name and names of the users it should be copied to.  

**DoseSpot Setup**  
DoseSpot is a method of sending electronic prescriptions in Open Dental. It is an internet based, secure ePrescribing system. DoseSpot integrates with Open Dental using a program link and offers two-way medication syncing. eConnector(1520) and an active support plan are required to register.  

- DoseSpot eRx Overview  
- Using DoseSpot(338)  
- eRx Companies(349)  

**Setup Overview**  
Note: You must have the eConnector installed. Make sure it is installed before beginning DoseSpot setup. See eConnector(1520).  

Part 1: Enable electronic Rx Program Link for DoseSpot.  
Part 2: Fill out Clinic/Practice and Provider registration forms.  
Part 3: Sign up for DoseSpot:  
1. Enter the Clinic Key and ID.  
2. Enter DoseSpot User ID.  
3. Enable additional clinics (optional).  
Part 4: Enable Non-Doctors.  
Part 5: Complete Identity Proofing.  
Practices using Legacy eRx(349) can choose to switch to DoseSpot (recommended) or continue using Legacy. Once DoseSpot is enabled, there is an option to keep Legacy eRx enabled to allow you to continue sending prescriptions.
electronically while the DoseSpot Identity Proofing process is underway. Once you have completed the transition to DoseSpot for all needed providers, call Open Dental support to cancel Legacy eRx.

**Part 1: Enable DoseSpot Program Link**

1. In the Open Dental Main Menu, click Setup, Program Links.
2. Double-click electronic Rx.
3. If available, select DoseSpot as the eRx Solution. If you are in the process of switching to DoseSpot from Legacy select DoseSpot with Legacy. Note: You will need to check the Allow Legacy eRx Option in the Provider Edit Window to allow continued use of legacy per provider until DoseSpot identity proofing is complete.
4. Check the Enabled box.
5. Click OK.

**Part 2: Fill out Clinic/Practice and Provider Registration Forms**

1. Designate a Practice Administrator for EPCS registrations (cannot be a doctor).
2. Complete the DoseSpot Registration Form.
   - Note: For each additional provider, use the same form and uncheck Clinic at the top. Each provider submitting electronic prescriptions needs to submit a Provider form.
   - To register additional proxy (non-provider) users, please send an email with their first and last names to erx@opendental.com.

The practice administrator will receive an email containing the Clinic Key, Clinic ID, DoseSpot User ID, and Practice Administrator registration. This could take up to two business days to receive.

**Part 3: Sign up for DoseSpot**

The following instructions are for the first clinic you register. For subsequent clinics, see the Additional Clinics section below.

Enter Clinic Key and Clinic ID
1. In the Open Dental Main Menu, click Setup, Program Links.

![Program Links](image)

2. Double-click on electronic Rx.
3. Double click the Headquarters clinic to open DoseSpot Property Edit window.

4. Enter the provided Clinic Key and Clinic ID.
   - Note: Once these fields are entered they cannot be edited.
   - If clinic information is missing, click Setup to open the Edit Clinic window and enter required information.

5. Click OK.

**Enter DoseSpot User ID**

1. Open Dental will automatically insert the DoseSpot User ID into the **DoseSpot User ID** field of the User Edit window only for providers. Providers will be notified via an eRx Alert when registration is complete.
2. The practice administrator must manually enter a DoseSpot User ID for non-doctors and providers with multiple ID numbers. See Part 4.
**Additional Clinics**: Once DoseSpot is enabled for the Headquarters clinic, registering additional clinics is easy. There is no charge for additional clinics.

1. In Open Dental, click Setup, Program Links.
2. Double click electronic Rx.
3. Double click the clinic you wish to register.
4. Click *Register Clinic*. The Clinic ID and Key fields will populate.
5. Click OK.
6. In the Chart module, click eRx. This notifies and updates Open Dental Headquarters.

**Part 4: Enable Non-doctors**

Non-doctors must be enabled manually. Below are the steps to complete this process for non-doctors. This process can also be used for providers in the event a provider DoseSpot User ID was not automatically entered in the DoseSpot User ID field.

Enter DoseSpot User ID to Send ePrescriptions: This is required for each provider and non-doctor who will be sending ePrescriptions.

1. Once you receive a DoseSpot User ID, in Open Dental, click Setup, Security Settings ([Global Security Settings](1107)).
2. Double click the user to open the User Edit window.

3. In the DoseSpot User ID field, enter the DoseSpot User ID. Click OK.

For providers with multiple DoseSpot User IDs (e.g. for different clinics), click [...] to enter a number per clinic.

The provider and non-doctor(s) may now access DoseSpot.

**Part 5: Complete Identity Proofing**

Important: Identity Proofing is typically completed for each provider upon first launch of DoseSpot. In the event Identity Proofing was not completed, follow the steps below.
This process only applies to prescribing providers. Each prescribing provider must complete identity proofing before sending ePrescriptions.
1. In DoseSpot, click the *Walk Me Through* menu item in the lower right.
2. Follow the steps on the screen to complete identity proofing.

- Note: You will create a PIN. This PIN is required every time an ePrescription is sent.
- You will receive a letter in the mail (your home address) from Experian that contains your Session ID needed for EPCS registrations.

**Register for EPCS**
There are two parts to register for EPCS.

**Part 1: Practice Administrator Login**
Your practice administrator is designated during the Sign Up for DoseSpot process above. This person will access the Administration Console in DoseSpot and enable EPCS for the registered provider(s).
1. In a web browser, navigate to [http://pss.dosespot.com/Admin](http://pss.dosespot.com/Admin).
2. Enter login information. Login information is sent via email when the clinic is registered for DoseSpot.
3. In the Administration Console, click Edit on the provider/clinician to enable EPCS.
4. Under TFA Authentication, check the EPCS/TFA Activation box.
5. Click Save.

**Part 2: Activate One Time Passcode (OTP) Device**
EPCS registration is required in order to submit electronic prescriptions for controlled substances. You will also need to download the Duo Mobile App from the [Google Play Store](https://play.google.com/store) or [Apple App Store](https://apps.apple.com).
1. Log into Open Dental as the provider who activated EPCS/TFA.
2. In Open Dental, select a patient.
3. In the Chart module, click eRx to open DoseSpot.
4. Click the notification alert in the upper left.
5. Click Activate TFA Authentication.
6. TFA Authentication window will pop up.
7. Enter the Credential ID generated from the Duo Mobile app. Do not include spaces.
8. Enter the Session ID from the Experian letter.
9. Enter the displayed 6-digit code from Duo Mobile app into the TFA Code field on the computer.
10. Enter in the provider’s PIN created during the IDP setup process.
11. Click Save.

You can now send both controlled and non-controlled substances electronically.

EHR Incentive Program: DoseSpot has superior features to Legacy eRx, but ePrescribing for the EHR Incentive Program is only possible with Legacy eRx - Comprehensive.

**TFA Activation and One Time Passcode (OTP) Method**
Deactivating Your Old Device:

If you have a new phone and are currently using the VIP Access App, and you still have access to your old device, you will need to deactivate your old device and activate your new device. If you do not have access to your old device, please contact Open Dental support.
1. Close out of DoseSpot if you have it open.
2. The DoseSpot admin (designated by the DoseSpot admin email in the commlogs) will need to login to the admin console [http://pss.dosespot.com/Admin](http://pss.dosespot.com/Admin).
3. The DoseSpot admin will click **Deactivate** in the TFA Authentication section.
4. The DoseSpot admin will click **Save**.
5. The provider will log into Open Dental, then select a patient and click **eRx** in the Chart Module.
6. The provider will click the blue ! at the top of the screen.
7. The provider will be prompted to click **Deactivate TFA Authentication**.
8. The provider will enter their Credential ID, TFA Code, and PIN (from their old phone).
9. To activate your new device, follow **Part 2: Activating Your One Time Passcode (OTP) Device** (see above).

If you have a new phone and are currently using the Duo Mobile App, you will not need to deactivate your old device in order to activate your new one.
1. The DoseSpot admin (designated by the DoseSpot admin email in the commlogs) will need to Login to the admin console [http://pss.dosespot.com/Admin](http://pss.dosespot.com/Admin).
2. Select the **Re-Send DUO Mobile** button in the TFA Authentication section.
3. Enter the new phone number.
4. Select the text messages that need to be resent so the provider can download and enable their Duo Mobile app.
5. To activate your new device, follow **Part 2: Activating Your One Time Passcode (OTP) Device** (see above).

---

**DoseSpot Alerts**

Providers, non-doctors, and clinics subscribed to DoseSpot will receive Alerts

In the [**Main Menu**](592), click **Alerts** (1635).

![Alerts](image)

Before alerts will display, each provider/proxy clinician and clinic must be subscribed to eRx Alerts. See [Alert Subscription](1113).

The eRx alert category includes the registered provider and registered clinic that are subscribed to the alert. Currently there are three eRx alerts. Two are informational, and one requires action (see below).

Select user to assign ID: This alert appears when multiple users are assigned to one provider, or no user is assigned. This alert requires action.

1. Click the alert, Open [DoseSpot](338) Assign User ID.

![Assign User ID](image)

2. **DoseSpot User ID**: The user ID that is assigned to the registered provider. This field cannot be edited.
3. **User to Assign**: Pick a user from the list, or click the picker button to open the Pick User window and assign a user.
4. Click OK to assign the selected user to the User ID shown.

**eRx Companies**

Electronic Rx (eRx) is an internet-based, secure method of sending electronic prescriptions in Open Dental accessed from the **Chart Module**.(298).

There are two options for sending electronic prescriptions.
- **DoseSpot eRx** (recommended): eRx, EPCS, two-way synching, insurance coverage import, drug-drug and drug-allergy interaction checks, mobile web accessible, alerts for pending prescriptions, and access to lexicomp. Also see [DoseSpot eRx / Prescription](338).
- **Legacy eRx**(349): eRx, EPCS, controlled compound drugs.

See [Fees for Support and Services](#) for pricing.

*An active support plan is required to sign up. eRx only works in the United States and its territories.

Note: Providers opting into the EHR Incentive program may only use Legacy eRx.

**Legacy eRx**

Legacy eRx is an internet-based, secure, electronic prescribing system ([eRx Companies](349)). It only works in the United States and its territories, including Puerto Rico.

Requirements:
- Valid Open Dental registration key. The key must be active (currently on support) to enable Legacy eRx.
- Internet Explorer.
- A high-speed connection for efficient use (cable, DSL, etc.).

Billing Details:
- Provider identity proofing fees will be added to your next statement.
- Monthly fees are billed in advance and appear on your statement the month after you first access Legacy eRx or use any feature in the interface.
- The EPCS fee of $150 is paid via PayPal to SureScripts during the registration process.
- If you ever stop using Legacy eRx, contact Open Dental support to cancel or monthly fees will continue.

For all issues (identity proofing, passwords, support, sign up) contact Open Dental Support only.

Note: Formulary checks only occur before dosing and will not display correctly after dosing has occurred.

**Getting started**

Contact Open Dental support. We will activate the service and walk you through identity proofing and credentialing.
- The provider must be present during the call and should allocate ~30 minutes of uninterrupted time. Open Dental will not assist with setup if the provider is not present.
- Enter required information in Open Dental prior to the call. See [Required Legacy eRx Information](371).
- The following documentation will be needed for credentialing so have it ready.
  - State license paperwork
  - DEA paperwork
  - NPI paperwork. If you do not have a copy of your NPI paperwork, see [https://nppes.cms.hhs.gov/NPPES/Welcome.do](https://nppes.cms.hhs.gov/NPPES/Welcome.do).
- State ID (e.g. driver’s license)
- It will take approximately 2 business days to approve credentials.

EPCS: EPCS sign up requires additional steps after identity proofing and credentialing have been approved and validated. Contact support for assistance.

**Related links**

**Setup**
- Legacy eRx Credentialing(354)

**EPCS**
- Legacy eRx EPCS Setup(358)

**Use**
- Writing and Transmitting Legacy eRx Prescriptions(351)
- Legacy eRx Allergies(350)
- Legacy eRx Medications(368)
- Legacy eRx Drug-Drug, Drug-Allergy Interaction Checks(357)
- Legacy eRx Drug Formulary Checks(373)
- Legacy eRx Pharmacies(370)
- Legacy eRx Doctor’s List(356)

**Other Resources**
- Training Resources for Legacy eRx(367)
- Report a Failed or Missing Prescription in Legacy eRx(369)
- Disabling Legacy eRx(355)
- IDP Troubleshooting (PDF)
  - Use the Cloud OTP as a Method to receive the OTP
- Legacy eRx Technical Details(372)
- Legacy eRx Frequently Asked Questions(365)
- Legacy eRx Troubleshooting(372)
- Basic vs Comprehensive Legacy eRx(367)

**State-Specific Resources**
- eRx New York(378)
- eRx Ohio(375)

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**Legacy eRx Allergies**

In Legacy eRx(349) a patient's allergies are listed under the Compose Rx tab. Legacy eRx uses the allergies entered here when checking for Legacy eRx Drug-Drug, Drug-Allergy Interaction Checks(357). Allergies entered in Open Dental are not currently passed to Legacy eRx; you must manually enter them.

<table>
<thead>
<tr>
<th>Allergy</th>
<th>Severity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aspirin</td>
<td></td>
</tr>
<tr>
<td>Penicillins</td>
<td></td>
</tr>
</tbody>
</table>

To add an allergy:
1. Click **Allergy / Intolerance**.

2. Enter all or part of the allergy (brand, ingredient, or drug category such as NSAID), then click **Search For Allergy**. You can also select a Common Allergy / Intolerance, or add a non-drug allergy if a match is not found.

3. Click the drop down to select the allergy severity level and onset date. Enter any notes.

4. Click **Save Allergy**. It will be added to the list.

---

**Writing and Transmitting Legacy eRx Prescriptions**

To write and transmit an electronic prescription in the **Legacy eRx**(349) interface, follow the steps below.

Other Resources:
- How to Write a Prescription in the Legacy eRx interface, Admin tab.
- Webinar: **Using Legacy eRx**

1. In the **Chart Module**(298), click **eRx**(349). Internet Explorer will open with the Compose Rx tab selected. If you do not see the interface, check the task bar to ensure that Internet Explorer is the focus.

2. In the **Drug Search** field, enter the medication name, then click **Drug Search**.
All matching results will display. If using the comprehensive version and you have attached an insurance formulary to this patient, formulary status appears in the first column. Click a formulary link to see therapeutic alternatives. See [Legacy eRx Drug Formulary Checks](#) (373).

3. Click on the medication name to select it.
If using comprehensive, monograph, leaflet and patient education links show at the top. Click to access. Once you select the drug, the system will check for severe drug-drug or drug-allergy Interactions and display an alert if applicable. To change medications, close the alert, then cancel and delete the order. Then repeat step 2 - 3.

The medication will be in a pending status.
4. Some information may automatically populate. Edit as needed. Frequency must always be selected. You may need to scroll up or down to find the correct dosage or frequency value.
   - **Note:** Additional Sig field is limited to 210 characters.
   - To associate an ICD code to the prescription, assign the code in the Procedure - Medical Tab (314) of a completed or treatment planned procedure in Open Dental before clicking eRx.
   - To save this medication to the doctor's Favorites List, check the box labeled **Save this sig and add to Doctor's List**.

5. Click Save Rx.

6. Review the current medication order for accuracy.
   - To make changes, click **EDIT**.
   - To remove the entire order, click [X].
   - To add another medication, repeat steps 2 - 4.
7. When you are finished entering medications, click **Take Complete Rx to Review Page** to proceed with the transmission.

8. When using Legacy eRx comprehensive, the system will check for interactions with current medications, allergies, and diagnoses and display applicable alerts. See [Legacy eRx Drug-Drug, Drug-Allergy Interaction Checks](#). If necessary, edit medications.

9. When you are satisfied with the medications entered, there are several options:
   - **Print Rx/Add to Current Meds**: Print selected prescription(s) and save the medication to the eRx list of current medications.
   - **Transmit Rx**: Proceed with transmitting selected prescription(s) electronically.
   - **Return / Additional Rx**: Create another prescription.

10. If you choose to transmit the prescription, the Transmit Rx window shows. Select the pharmacy to send the prescription to.

If prescribing a controlled substance, select a pharmacy denoted with a C on the green dot. These pharmacies can handle the electronic transmission of controlled substances.

11. For non-controlled substances, click Transmit Rx/Add to Record to transmit the prescription.

12. For controlled substances, choose one of three options:
   1. Click **Send Push Notification** in Legacy eRx interface. The provider will receive a notification on their mobile device. Click **Approve or Deny**.
   2. Click the Hardware Token radio button in the Legacy eRx interface. Press the button on the hardware token, and enter the generated code into the **Enter Code** field.
   3. Open the Authy App and enter the displayed code.

The completed prescription will automatically copy to the patient's medication list and Progress Notes when you do one of the following:
- The first time the Chart module is opened after a patient is selected.
- After clicking the eRx button, then closing the eRx window.
- Manually clicking the eRx drop down in the toolbar, then Refresh.

To set up automation options in Open Dental, see [Automation](#), RxCreate trigger.

Discontinued medications: When a medication is marked as discontinued in Legacy eRx, the medication will also be marked discontinued (Stop Date entered) in Open Dental when the Chart module is refreshed.

EHR users: Check to make sure [RxNorms](#) are attached to medications.

Periodically check for rejected prescriptions so no prescriptions slip through the cracks.

To electronically prescribe controlled substances you must go through additional identity proofing and set up two-factor verification.

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**Legacy eRx Credentialing**

Credentialing is part of the process of [Legacy eRx](#) identity proofing. It entails submitting credentials to further confirm provider identity.

**Note:**

Make sure the information you submit is accurate.

First complete identity proofing. When that is complete, send an email to providerverification@newcroprx.com that contains the following information.

**To:** providerverification@newcroprx.com  
**Cc:** erx@opendental.com
Subject: (provider name) Credentialing

Email address: Email address you used during Exostar identity proofing.

Mobile number: Personal mobile number. This will be used once for verification purposes only.

Mobile carrier: Cell phone carrier

Office address:

Office phone:

Contact person: Any person, other than the provider, who can verify the practice is active (e.g. office manager).

Software: Open Dental

Legacy eRx Version: Basic

Also attach scanned copies of the following documents, or they can be faxed to 832-553-1889.

- State license paperwork
- DEA paperwork
- NPI paperwork. If you do not have a copy of your NPI paperwork, see https://npiregistry.cms.hhs.gov/
- State ID (e.g. driver’s license) in color or grayscale. Black and white is not permitted.

Once credentials have been submitted, it will take approximately 48 hours to finalize. You will receive a confirmation email from Open Dental. We will then activate electronic transmission of prescriptions on your account and apply the one-time identity proofing fee to your statement.

Once credentialing is complete, you can begin writing prescriptions and sign up for EPCS (Legacy eRx EPCS Setup(358)).

Disabling Legacy eRx

To stop the monthly Legacy eRx (349) service fee, contact Open Dental technical support.

You also need to disable Legacy eRx in Open Dental to block users from clicking eRx and accumulating accidental charges. The support technician will walk you through disabling when you call.

- Disable the Legacy eRx program link to block all providers from accessing Legacy eRx.
- Disable Legacy eRx for an individual provider to block a single provider from accessing Legacy eRx. It will also block access to Legacy eRx when the provider is the patient’s primary provider and no other authorized provider is logged on.

Disabling the eRx Program Link

1. In the Main Menu(592), click Setup, Program Links, then double click electronic Rx.

2. Uncheck Enabled.
3. Click OK to save.

Disabling Legacy eRx for individual providers:

1. In the main menu, click Lists, Providers(1252), then double click the provider.
2. Uncheck **Use Electronic Prescriptions (eRx)**.

3. Click OK to save.

**Questions & Answers**

**Q:** I disabled Legacy eRx for a provider, why am I still seeing additional charges?

**A:** Complete the following steps:
- Contact Open Dental support and request to cancel the service.
- Disable access to Legacy eRx in Open Dental. This can be done for all providers (via the program link) or for a single provider (via Edit Provider window).

Any usage charges accumulated before cancellation will be reflected within two billing cycles.

**Q:** Why do I not see an option to disable Legacy eRx for an individual provider?

**A:** Update to version 16.3 or greater.

**Legacy eRx Doctor’s List**

In the Legacy eRx(349) interface you can create a list of frequently prescribed medications. This list is called the Doctor's List or Drug List.

1. On the **Compose Rx** tab, type the first few letters of a brand or generic name and click **Drug Search**.
2. In the results, click on a blue link to select the drug tablet size or formulation.
3. On the Pending Rx window, enter the sig. Check **Save this sig and add to Doctor’s List**.

4. Click Save Rx and then proceed with writing the prescription.
Select a medication from the Doctor's List
1. On the Compose Rx tab, click **Doctor's List**. A new section will show on the window listing the provider's Favorites List.

2. Click a blue link to select the drug, then proceed with writing the prescription.

To remove a drug, check the box next to it, then click **Remove from List**.

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Legacy eRx Drug-Drug, Drug-Allergy Interaction Checks

In Legacy eRx (349) comprehensive version, drug-drug and drug-allergy interaction checks are automated. You must contact Open Dental to turn on this feature.

- **Drug-Drug**: Prescriptions are checked against current and pending medications listed on the Compose Rx page.
- **Drug-Allergy**: Prescriptions are compared to patient allergies listed on the Compose Rx page.

At this time, the patient's allergy and medication list in Open Dental is not passed to Legacy eRx. If an allergy or medication is not listed, see Legacy eRx Allergies (350) or Legacy eRx Medications (368).

**Allergy and severe/contraindicated interactions**

When searching for, then selecting a drug in Legacy eRx, the system automatically checks for allergy and contraindicated/most severe interactions. The alert looks like this:

To cancel the order of a medication that has triggered an interaction alert:
1. Close the alert. The medication will still be pending.
2. Click Cancel in the middle of the screen.
3. The medication will still be listed in the Pending Rx area. Click [X] to delete it.

---

All interactions
If the system is set to check for all interactions, regardless of severity level, a summary of all interactions (drug-drug, drug-allergy, drug-disease) will show on the Review page. Click More Info to view complete information on a potential interaction.

- Contraindicated appears in red and indicates a predictably severe consequence of concurrent use of two drugs.
- Severe appears in yellow and indicates action may be required to reduce the risk of adverse reaction.
- Moderate appears in yellow and generally indicates a need to adjust medications.

### Legacy eRx EPCS Setup

Electronic prescribing of controlled substances (EPCS) is available using Legacy eRx(349). This process is required by the Drug Enforcement Agency (DEA) to register and prescribe scheduled drugs. There may also be additional steps required by a provider's state.

**Note:** EPCS setup differs depending on your eRx solution. See DoseSpot Setup(343) for EPCS steps using DoseSpot.

**General Setup Steps**

1. Download the Authy app.
2. Enable Legacy eRx and complete Identity Proofing (IDP) if you have not already done so.
3. Obtain an EPCS License for each provider who will prescribe controlled substances.
4. Enter identity proofing credentials.

We recommend updating to the current stable version.

**Subscribe for EPCS**

All providers who want to prescribe controlled substances must obtain an EPCS license.

Make sure the provider is logged on to Open Dental (in Open Dental the provider must be associated to a user. See User Edit(1109)).

1. In the Chart Module(298), click eRx to open the Legacy eRx interface.
2. Click the Admin tab.
3. Click Exostar Sign-up.
4. Click Sign Up for EPCS Services.

For the step by step guide to complete this process, please contact your EMR or click here: EPCS User Guide.
5. Check the box next to the provider(s) to register for EPCS Subscriber Licenses, then click **Calculate**.

<table>
<thead>
<tr>
<th>Active</th>
<th>Name</th>
<th>DEA</th>
<th>Expires</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>Chuck A. Noms</td>
<td></td>
<td>2/6/2016 12:23:55 PM</td>
</tr>
<tr>
<td>Yes</td>
<td>John A. Smith</td>
<td></td>
<td>1/8/2016 5:23:45 PM</td>
</tr>
<tr>
<td>Yes</td>
<td>George Washington</td>
<td></td>
<td>1/8/2016 11:43:57 AM</td>
</tr>
</tbody>
</table>

6. If the Total Cost is accurate, click **Purchase**.
7. Click **Transfer to PayPal Portal** to complete your payment in PayPal.
8. If you have a PayPal account, click **Have a PayPal Account**, then login. If not, you can pay as a guest by entering credit card and billing information.
9. After a successful transaction, you will receive a confirmation email from PayPal. If you do not want to pay via credit card online, PayPal offers 'Bill Me Later' to pay by check. Click **Print Receipt** to print a receipt.
10. To proceed with EPCS setup, click the tab in your browser to return to Legacy eRx.
11. Click **Click here** at the bottom of the screen to return to EPCS registration screens in Open Dental.
12. Enter the address currently listed on the provider's driver's license and current email address. Before clicking save, verify the DEA number is correct.
13. **Click Save.**

Hardware Token: You will receive a hardware token as part of your registration. Your hardware token is a physical device that generates a One Time Passcode (OTP). You can choose to have your hardware token shipped to the location (practice/clinic) address or home address. Click the preferred shipping address, verify it is correct, and click **Order Token and Continue Registration.**

Note: Only click each button once. Some buttons respond slowly.

**Exostar Registration** Click **Click to Start EPCS Registration Process** to begin.

Once this button is clicked, the Exostar pages will open and you will begin the identity proofing process.

**Identity proofing with Exostar**

Note: Click each button only once. Some buttons respond slowly.

1. Review the Subscriber Agreement. Click **I Agree.**
2. Confirm profile: Select United States from the dropdown and click **Submit**.
3. Verify identity.
   1. Enter all of your personal information. Review carefully. Once information is verified as correct, click **I Agree**.
   2. You will be presented with questions that will be used to verify your identity. Read all questions carefully. When all questions are answered, click **Next**.

   **Note:** If you are unable to be approved during the registration process, you will be provided with one of the two alternative methods below.
   - Webcam proofing
   - US mail

3. Bind Token/App - Choose option A or B.

   **Note:** If you choose to use the Authy app (option b), you do not need the token but you will still receive one.
   1. Your hardware token will arrive in approximately one business week. See Bind Hardware Token section below for steps, or click **Skip** to Next to bind your token using the Authy app.
   2. Use the Authy app to generate your OTP. To bind the app to your profile, enter your phone number. Click **Register Phone**. If you have not yet downloaded the app, you will receive a text message with a link to the downloaded app.
3. Open the Authy app. Follow the on-screen instructions.
4. In the Legacy eRx window, continue to next steps.
5. Click the red X and enter the 6 digit passcode from the Authy app into the **Soft OTP** field.
6. Click **Submit**.

7. You will see confirmation that the app is now bound to your profile. Click **Complete**.

**Accessing your Exostar Profile**

To access your Exostar profile, you must authenticate using either one of your OTP methods or via a text message or voice call. It is important that you set up text messaging or voice call in the event that you do not have access to your OTP method and would like to add a new OTP method. If you are unable to access your profile, the current profile will be revoked and you are required to re-start the entire process.

1. Enter your cell phone number to receive a text in order to authenticate to your profile. Select the Country, enter and verify the phone number to text. Click **Send Code**.
2. If you would prefer to have a voice call, change the first drop down to voice call. Enter and verify the phone number to call.
3. Click **Call**.
4. Enter the Verification Code that was sent. Click **Submit**. Once your profile is set up, you can add more than one authentication number to your profile.
5. Click **Complete**.
You have now completed the Exostar registration process. You can manage the OTP devices in the Admin Tab, Manage Your EPCS Account link. Once the process is completed in Exostar, there are two last steps must be completed. These steps are called the Grant and Finalize steps.

**Grant and Finalize**

**Grant Step**

The DEA requires an EPCS Administrator to confirm the identity of the Prescriber. This is called the Grant Step. Anyone on the list who is not the Prescriber can complete the Grant Step as the EPCS Administrator.

1. Check the box next to both the EPCS Administrator’s name and your own name.
2. Click **Save**. The Prescriber logs out of Legacy eRx.

In the example below, Timothy Applegate is the Prescriber and Amber Valentine is the EPCS Administrator.

3. The EPCS Administrator logs into Legacy eRx, clicks on the Admin tab and chooses the Prescriber Registration and EPCS Setup link.
4. The doctor’s name now appears in the box with Select underlined in blue.
5. Click **Select** next to the Prescriber’s name. The EPCS Administrator logs out.

**Finalize Step**

1. The Prescriber logs back in, clicks on the Admin Tab and chooses the Prescriber Registration and EPCS Setup link. The Prescriber’s name will appear in the Finalize Step box.
2. Click **Select**.

3. The Enter OTP box will appear. Use the OTP option that was bound during registration to complete the Finalize step.
   1. Authy App: Open the Authy App on your mobile phone. Enter the One Time Passcode from the Authy app into Legacy eRx. Click **Authenticate**.
   2. Hardware Token: Click Hard Token. Click the button on the hardware token and enter the One Time Passcode into Legacy eRx. Click **Authenticate**.

You have completed the EPCS registration process. You are now able to transmit controlled substances.
**Bind Hardware Token**
You will receive a hardware token in the mail. Use either the hardware token or the Authy app to authorize your account.

1. In the Legacy eRx window, Admin tab, click **Manage Your EPCS Account**.

2. Click **Authenticate** to receive an authentication code by text/call or through the Authy app.

3. In the Soft OTP field, enter the code you received in Step 2.
4. Click Add Token.

5. Enter the serial number found on the back of the hardware token.
6. Click the hardware token button to generate One-Time Password 1, and enter it in the field. Click the button again to generate One-Time Password 2, and enter it.
7. Click Submit.

Legacy eRx Frequently Asked Questions
Below are questions frequently asked about prescribing using Legacy eRx(349).
Use

When are prescriptions copied into Open Dental?
Completed Legacy eRx prescriptions are automatically copied to the patient's Medication List and Progress Notes when the following occurs:

- The first time the Chart module is opened after a patient is selected.
- After clicking the eRx button, then closing the Legacy eRx window.
- Manually clicking the eRx drop down in the toolbar, then Refresh.

Who is the provider on the prescription?
The provider shows in the upper right of the Compose Rx window; the staff shows in the upper left.

- If the currently logged on user is associated in Security with a provider, then that provider is used.
- If the currently logged on user is associated with an employee, not a provider, then the patient's primary provider is used.

How do I block an employee from writing prescriptions?
Remove the Rx Create security permission. Employees who have this permission are treated as staff and have the ability to write prescriptions on behalf of the provider.

How are clinics assigned?
The patient's clinic is used when the prescription is sent. Providers must be registered with the same clinic as the patient. If patient has no clinic assigned, then the practice information is used.

Why does the provider get a popup window when attempting to send EPCS that asks for user name and password?
This is a new requirement starting 12/15/2016. It is not an error. All providers need to enter their Verizon UIS user name and password every time they transmit a controlled substance prescription and follow the on-screen prompts.

Setup and IDP

Why do I need to go through identity proofing?
SureScripts requires that every provider complete identity proofing to electronically transmit prescriptions. This process verifies you are who you say you are by asking a series of questions for which only you know the answer. You will also set up a device (e.g. a mobile phone) that will receive a one time passcode used for verification. Legacy eRx uses Verizon UIS (Universal Identity Services) for identity proofing. Verizon UIS is separate from Verizon's phone service and a Verizon phone is not required.

Why do some of our practice's providers have to complete identity proofing for Legacy eRx and others don't?
Identity proofing is a newer requirement for electronic prescriptions. Providers who were using Legacy eRx prior September 2015 were grandfathered in and do not need to go through identity proofing to send prescriptions electronically. Providers who sign up in September 2015 and after will have to complete identity proofing before they can e-prescribe. Contact us to begin the process.

What are One Time Passcodes (OTP)?
These passcodes are generated by Verizon UIS and sent to the code device you specify during setup. The code is only good for a certain number of minutes. If a code expires and you attempt to enter it, the authentication will fail. Just try again with a new code from your device.

I have a new email address. How do I change it for eRx/Verizon UIS?
1. Click My Profile, View My Profile, Edit.
2. Enter the new email address.
3. Click My Certificate and Reissue the Certificate. In the drop down, choose the new email address. This will tie the certificate to the new email.
4. Resign the Subscriber Agreement.

I already completed Identity Proofing (IDP) when I signed up for Legacy eRx. Do I need to go through IDP again for EPCS?
No. You will be asked to supply the exact information (name, address, email, Verizon UIS user name and password) that you supplied during the IDP process, but will not need to go through the entire process.
I already use eRx, but IDP was not yet required. If I want to sign up for EPCS, do I need to go through IDP?
Yes, you do need go through IDP for EPCS.

What is an EPCS Administrator?
EPCS administrators authorize providers for EPCS. The DEA requires that you have at least two EPCS administrators. At least one must have an EPCS license (EPCS Activated = Yes).

For offices with only one prescribing provider, you can set up a different user (e.g. office administrator) in Open Dental that only uses Legacy eRx as an EPCS Administrator (not prescriber).

I have purchased the EPCS license, completed identity proofing, and assigned an EPCS administrator. Now I am unable to authorize EPCS privileges and I can't click the 'Select' link in the interface. What is wrong?
Before you can authorize or finalize EPCS privileges, you must set up two valid EPCS administrators. Both administrators must have a profile set up in Open Dental, and have clicked through to Legacy eRx (log in to Open Dental, click New eRx). The 'Select' link will become clickable once two valid administrators are set up. One administrator must be an EPCS activated provider. The other administrator can be a provider or a user who does not prescribe.

Basic vs Comprehensive Legacy eRx
Below is a short description of the difference between the basic and comprehensive versions of Legacy eRx. This table has been ommitted.

- Comprehensive Drug List: Database of drugs.
- Indexed Health plans and Pharmacies: Lists of insurance carriers and pharmacies in your area.
- Drug Interaction Checks: Automated drug-allergy and drug-drug interaction checks when prescribing medications.
- Legacy eRx Drug Formulary Checks: Assign formularies for specific health care plans to patients, then automatically check formularies when prescribing medications.
- Patient Leaflets: Educational materials that can be printed. Look for the Patient Education Leaflet link when you print or transmit a prescription. You can also view leaflet information in drug search results or medication details (click the magnifying glass icon next to a medication). A record of leaflet selection is tracked in Rx Detail.
- Herbals: Herbals can be prescribed in eRx - Comprehensive. Interactions will not be characterized as to severity due to lack of standardized content and dosage.
- Drug Monographs: First Data Bank comprehensive monograph.
- Identity Proofing Required: Identity proofing and credentialing with Verizon UIS is required for all providers who wish to electronically transmit prescriptions. There is a one-time fee per provider.
- Controlled Substances (EPCS): To electronically prescribe controlled substances, the DEA requires additional identity proofing and two-factor verification. There is an additional annual fee for the EPCS License.

Training Resources for Legacy eRx
If you are using Legacy eRx, the following resources may be helpful.

- Webinar: Using Legacy eRx

External resources
To access some of the areas below, you need to launch Legacy eRx (click eRx in Open Dental).
• Video: Click the Admin tab (under Orientation Views).
  o Orientation Video Part 1
  o Orientation Video Part 2

• Read Me First Documentation: Click the Admin tab (under Support).
  o How to Write a Prescription
  o Administrative Page Functions
  o Online help for each screen (click the links at the bottom of each screen)
    ▪ Popup Help: Display help information in a new window.
    ▪ Help: Show help information at the bottom of the current screen.

• Audio Tour: Click Resources in the top left corner of the Legacy eRx interface, then Tour at the bottom of the page.

  • Compose Rx Video (YouTube)

Hints

• Legacy eRx will configure itself with use. The more you use it, the more information that will be available.
• Use the tabs across the top of the interface to move through the system.
  o Select Dr./Staff: When you launch from Open Dental, the doctor/staff is passed to eRx.
  o Compose Rx: Where each new prescription begins.
  o Med Entry: Enter a medication without prescribing.
  o Patient Details: General patient information. This field usually automatically populates.
  o Diagnoses: Patient diagnoses and past medical history. Used for drug disease checking.
  o Admin: Training materials, health plan and pharmacy lists.

Legacy eRx Medications
In Legacy eRx (349), a patient's current medications are listed under the Compose Rx tab. Legacy eRx uses the medications entered here when doing Drug Interaction Checks (357). When you write and transmit an electronic prescription, the medication will automatically list here. However, medications entered directly in Open Dental are not currently passed to Legacy eRx; you must manually enter them.

If a patient's current medication is not listed:

1. Click the Med Entry tab.
2. If needed, change the provider in the upper left and enter the start date.
3. Enter the first few characters of the drug name, then click Drug Search.
4. Select the strength.
5. (optional) To enter more details about the med, click EDIT, select the information, then click Save Rx.
6. Click Select to move to Current Meds in the upper left.

The medication will be added to the Current Medications list with a tan background to indicate it was added via the Med Entry tab.

To discontinue a current medication, check the pink Select box, then click D/C. The medication will also be marked discontinued in Open Dental when the Chart module is refreshed (a Stop Date will be entered). To change a current medication, click EDIT.
Report a Failed or Missing Prescription in Legacy eRx

If you think a prescription failed to transmit electronically or a pharmacy or patient claims to have not received it, first research the issue, then if needed, report it to Legacy eRx (349).

Criteria to research a missing prescription:
- It must be electronically transmitted. SureScripts does not track faxed prescriptions.
- It must be no more than 5 days from the write date of the prescription.
- Mail order prescriptions: Allow 72 hours from transmission before reporting a prescription as failed or missing. Mail order pharmacies have 72 hours to update their database with prescriptions.

1. In eRx, Compose tab, click on the magnifying glass to the right of the current medication to view current details.

   ![Current Medications for Kim Gardner](image)

2. Scroll down to the Print / Transmission Log.

   ![Print / Transmission Log](image)

3. Reading from bottom to top, check the Route (electronic, faxed, printed) and Status (queued, success, failure).

Report a failed transmission
A transmission is considered failed when the Route is Electronic and Status is Failure.

Click Report Failed Transmission. An email will be automatically sent to Legacy eRx to research the reason for failure. When an explanation and outcome is determined, you will be notified.

Report a missing prescription
If a prescription status is success but the pharmacy or patient claims to have no record of the prescription, report the prescription as missing.

1. Click Report 'Missing' Prescription.
2. Fill in the two required fields:
   - Who reported to the provider or practice that the prescription is missing? Do not send PHI. If a pharmacist, please enter their name.
   - What did the pharmacy or patient say?
3. Click Report Missing Rx to report it. An email will automatically be sent to Legacy eRx to research the issue. When an explanation and outcome is determined, you will be notified.

Legacy eRx Pharmacies

When using Legacy eRx, there are several ways to select the pharmacy.

Select pharmacy at time of transmission
1. Write the prescription.
2. When you reach the Transmit Rx page, pharmacy options will list at the bottom.
3. Click Add Pharmacy.
4. Search for the pharmacy by zip, phone, fax, name, or location information. Matching results will list.
5. Click on the pharmacy name to select it.

Maintain a master list of pharmacies
As you add pharmacies to patients, the master list will automatically update. You can also add commonly used pharmacies directly to the list.

1. In Legacy eRx, click the Admin tab.
2. Under Lists, click Location Pharmacy List.
3. Click Add Pharmacy.
4. Search for the pharmacy by zip, phone, fax, name, or location information. Matching results will list.
5. Check the box next to pharmacies to add, then click Add Checked Pharmacies.

Attach a preferred pharmacy to a patient
It first must exist in the master list.

1. In Legacy eRx, click the Pt. Details tab.
2. Under Patient Pharmacies, click Modify List to add/update patient pharmacy list.
3. Choices from the Location Master List will show. You can also search for a pharmacy by name, address or phone. Matching results will list.
4. Check the box next to the patient's preferred pharmacy, then click Save Changes. Multiple selections are allowed.
**General information**

On the Transmit Rx page:

- A green dot under the eRx column indicates the pharmacy can accept prescriptions electronically. A green dot surrounded by a C indicates the pharmacy can accept controlled substance prescriptions electronically.
- If there is no green dot in the eRx column, the prescription will be faxed to the pharmacy. The fax number must be listed or entered prior to transmission.

For more information about pharmacies in Legacy eRx, click Help in the Legacy eRx interface.

**Required Legacy eRx Information**

General requirements to use Legacy eRx (349):

- A valid Open Dental registration key.
- Update to the most current stable version.
- Internet Explorer.
- A high-speed connection (cable, DSL, etc) is necessary for efficient use.

If any of the following requirements are not met when you enable Legacy eRx, you will get an error message when you click the Legacy eRx button in the Chart module.

- To enable or create prescriptions, the logged in user must have the Rx Create permission. See Permissions (1118).
- Due to strict data requirements, the following information must be entered before you can send a prescription:
  - Practice (Practice Setup (931))
    - Practice phone (10 digits)
    - Practice fax (10 digits)
    - Practice address, including a city name and a 2 character US state abbreviation (all caps) with a 9 digit zip code. Cannot be P.O. Box.
  - If Clinics are enabled, enter the following information for each clinic that will send prescriptions. (Clinic List (1223))
    - Clinic phone (10 digits)
    - Clinic fax (10 digits)
    - Clinic address including a city name and a 2 character US state abbreviation (all caps) with a 9 digit zip code. Cannot be P.O. Box.
  - For each provider who will send prescriptions, enter the following information. Provider cannot be marked as a non-person. (Providers (1252))
    - First name (only letters, dashes, and spaces allowed; no special characters)
    - Last name (only letters, dashes, and spaces allowed; no suffixes or special characters)
    - A 10 digit NPI
    - A valid DEA Number (if you do not have a DEA number, enter 'none')
    - A valid State License ID
    - A valid State Where Licensed
  - Patient
    - Valid birth date. Entered in Edit Patient Information (62)
    - If the patient state is not blank, it must be valid. Entered in Edit Patient Information (62)
    - Height and Weight. Entered in Vital Signs (474)

NDCs: All transmitted medications must have an associated NDC (National Drug Code) which is assigned by the FDA whenever a new drug enters the market.
Legacy eRx Technical Details

The information below includes technical information about Legacy eRx (349).

How are users with multiple locations or providers tracked?
- There are three identifiers that Legacy eRx uses to divide information logically: AccountID, SiteID, and LocationID.
- For each unique AccountID and SiteID pair, a unique database is created at Legacy eRx. Open Dental always sends a SiteID equal to 1, therefore unique Legacy eRx databases will only be created for each unique AccountID.
- Legacy eRx Provider IDs (Open Dental ProvNums) must be unique for each Legacy eRx AccountID, and to meet this requirement, Open Dental automatically creates a unique AccountID for each logical database the first time an electronic prescription is sent from that database.
- Legacy eRx Provider IDs (Open Dental ProvNums) must be unique for each Legacy eRx AccountID, and to meet this requirement, Open Dental automatically creates a unique AccountID for each logical database the first time an electronic prescription is sent from that database.
- The AccountID format is the Open Dental customer account number followed by a dash followed by 5 random alphanumeric characters. For example, 1234-T2d28. There is no way for the user to edit the AccountID.
- Open Dental always sends a LocationID of "0" if clinics are not being used. Otherwise, the ClinicNum is sent for the LocationID. Within the Legacy eRx interface, the user can view information for a single location or for all locations.

Prior to version 13.2.21, disabling Legacy eRx removed the existing Account ID, and if re-enabled later, a new Account ID would be generated. In later versions, the Account ID is only disabled, not removed.

The Legacy eRx database will be LexiComp if and only if the first Legacy eRx click occurs when the Open Dental version is 15.4 or greater. Otherwise, the Legacy eRx database will be FBD.

All providers that share the same NPI number are treated as a single provider for eRx purposes.

GUID values: When electronic prescriptions are copied into the Chart module (when Chart module is refreshed), corresponding prescriptions and medications in Open Dental are identified by a GUID value supplied by Legacy eRx. The GUID is how Open Dental determines if a record has already been created.

Legacy eRx Troubleshooting

Below is troubleshooting help for Legacy eRx (349).

Problem: I keep getting a message that information is missing. What information is required for Legacy eRx?
Solution: See Required Legacy eRx Information (371)

Error: SubmitTransaction error: 2001: Invalid UUID.
This means you have skipped the identity proofing and credentialing process with Verizon UIS. You must do IDP before you can authorize or finalize EPCS privileges.

Problem: eRx Button turns red.
This can occur when eRx is clicked in the toolbar, or when switching to the Chart module, causing Open Dental to attempt a sync with Legacy eRx to automatically copy completed prescriptions into the patient's Medication List and Progress Notes.

Solution: The button turns red when Open Dental has attempted to communicate with Legacy eRx and failed. It may be that communication failed for a random reason. First try reloading the Chart module to see if the problem fixed itself. If the
problem continues, you need to determine what is causing the failure to communicate, then address it. Some common causes are listed below.

1. Intermittent internet connection issues or internet down. To determine if it is an internet issue, in an internet browser go to google.com and refresh the page. If the page will not load, there might be an internet issue.
2. Hardware Firewall issue: If all computers connected to the hardware are experiencing the same issue, it could be a hardware firewall issue. If two workstations use the same networking components and one works while another does not, it is not a hardware issue. Instead see #3 below.
3. Software desktop firewall issue: Open specific ports, or add an exception to the software firewall for the Open Dental application. Adding an exception for Open Dental would also allow other communication from Open Dental in the future (e.g. other web service communications as a result of new features).
4. Anti-virus software: Add an exception to the Open Dental application for the same reason stated in #3.
5. DNS: On the workstation with the error, open a web browser and type in “secure.newcropaccounts.com”. If DNS is working, you will get an access forbidden message. Assuming your internet is working, if DNS is not working, you will see a “404 page not found” message.
6. If you do not use electronic prescriptions, consider disabling the electronic Rx program link in Setup, Program Links.

**Problem:** When eRx button is clicked, receive error: “a technical error has occurred and has been automatically reported to your EMR/PM vendor”.

**Solution:** If you are using AVG and the AVG web tuneup plugin, it may be blocking the XML data from being sent to Legacy eRx. First try disabling the web tuneup plugin. If that doesn't work, try adding an exception in AVG. If that fails, you may need to remove AVG and use another anti-virus solution.

**Problem:** When trying to transmit controlled substances: There was an error: url: https://universalid.verizon.com/toolkit/index.php/?messagecenter/authorizeTransaction 3932329 Date Time ("method":"completeTransaction")

**Solution:** Clear our the cookies and cache in your browser. Shut down and try again.

**Problem:** Pharmacy claims they did not receive a transmitted controlled substance prescription.

**Solution:** Only pharmacies that are indicated with a C around a green dot can accept electronically transmitted controlled substances.

If the pharmacy indicates it can accept electronically transmitted controlled substance prescriptions, you should report the prescription as missing. See [Report a Failed or Missing Prescription in Legacy eRx](#) (369).

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**Legacy eRx Drug Formulary Checks**

Drug formulary checking is only available in the comprehensive version of Legacy eRx (349). For EHR measure details, see [EHR Objective 4: ePrescribing](#).

**Insurance:** Insurance information from Open Dental is not passed to Legacy eRx.

**Required Setup:** You must complete two steps to set up drug formulary checks:

1. Add health plans to your eRx Account Healthplan/Formulary list. Health plans are preloaded in Legacy eRx.
2. Attach health plans/formularies to patients.

If you cannot find the desired plan, try a different or shorter version of the name. Contact customersupport@newcroprx.com with the missing plan. Medimedia currently provides information for 3400 plans nationally and will endeavor to add any missing ones.

Once set up, checks will occur automatically when you [Writing and Transmitting Legacy eRx Prescriptions](#) (351).

**Add health plans to your account list**

1. In the [Chart Module](#) (298), click eRx to open the Legacy eRx interface.
2. Click the Admin tab in the upper right corner.


4. Click Add additional healthplans.

5. Check the boxes next to all health plan(s) you want as options for patients, then click Add To List. By default, choices for your state are listed. You can also search for national accounts.

All selected health plans should now list under the Current Account Healthplan / Formulary List.

**Attach a health plan/formulary to a patient**
1. In Open Dental, select the patient, then open Legacy eRx.
2. Click the Pt. Details tab.
3. Click the appropriate dropdown for the health plan (Primary, Secondary, etc.) then select the patient's health plan. Only plans added to the Current Healthplan / Formulary list will show.
4. Click Save Insurance / Formulary.

The health plan is now attached to this patient. Legacy eRx will automatically check the formulary whenever drugs are searched and indicate formulary status.

**eRx Ohio**

There are some additional steps required by Ohio prescriptions (paper or eRx(349)). Below is set up information to help you comply.

**Paper Prescriptions** Paper prescriptions generated in Open Dental can be customized using sheets. See Rx Layout(1181) or Rx Multiple Layout(1184).

Written prescriptions: Cannot use check boxes to determine if generic substitution is permitted. The rule states that the prescriber must hand write in wet ink “DAW” or Dispense as Written. For an XML prescription template that matches the format requirements, see Open Dental forum post Ohio Rx Template.

**Controlled substances**: Ohio requires that prescriptions for controlled substances include a CDT procedure code. We are currently working to link the prescription to the procedure code in Open Dental. In the meantime, here are two possible solutions.

- Add a static text field, surrounded by a rectangle box, then handwrite the CDT code once it is printed.
- Add ServiceNote as a static text field (see Sheet Static Text Field(1133)) then enter the procedure code in the service note field of the Medical(466). The downside is that you may have to clear out any other service notes you have already entered and clear the code after printing the prescription.

**Legacy eRx Users**

If using eRx, Ohio requires the following from providers who e-prescribe. Below are instructions if using Legacy eRx(349).

- **Controlled substances**: Prescriptions for controlled substances must include a CDT procedure code. In Legacy eRx, add the CDT code to the pharmacist's message on the Pending Rx window (see Writing and Transmitting Legacy eRx Prescriptions(351)). To set up automation options in Open Dental, see Automation(809), RxCreate trigger.
- **Prescriber Report**: Pursuant to OAC 4729-5-01(N), you must review and sign a Prescriber Report every day. This report provides legal signatures on electronic prescriptions and fax.

To generate in Legacy eRx:

1. In the interface, click the Admin tab.
2. Click Prescriber Report.
3. Select the date, then click Printer Friendly.

Select the doctor: Albert, Brian L. ○ (Last report generated 2015/09/28)
Select the report type: All Prescriptions (Ohio) ○

Select the date range: (For a single day, select on both calendars)

Quick pick single month report: Jan. 2015 Update Calendar

Reports greater than one month will time out: use a smaller time span.

Start Date: Oct

End Date: Oct

Click Printer Friendly to display a report in printable format.

Reports must be kept on-site for a minimum of three years

4. Click Print to print the report.
5. Sign the report. You must keep all reports on site in a folder/notebook for at least 3 years.

**Reminder to Review/Sign Prescriber Report:** Use **Automation** (819) to set a daily electronic reminder to sign and review the Prescriber Report.

**Mid-Level Provider Requirements:** To set up a mid-level provider:
1. In the **Providers** (1252), create a new provider. In the **Suffix** field, enter the Ohio credentials required. In the **State License Number** field, enter the mid-level provider’s CTP#.
2. Create a **User Security Profile** (1109) and attach the user to the provider.

Now when logged in as the mid-level provider, the information required by Ohio will be sent to Legacy eRx.
eRx New York


Each individual practitioner, not the software vendor, is required by regulation to register their certified EPCS software application with BNE. See https://www.health.ny.gov/professionals/narcotic/electronic_prescribing/ for more compliance information.

Below is information that may be useful when registering Open Dental and Legacy eRx(349).

- Copy of third party audit letter approving Open Dental for e-prescribing of controlled substances: EPCS Certification Letter (PDF).
- Name of the company providing the certified EPCS software application: Open Dental.
- Name of the certified EPCS software application: Open Dental Software using NewCropRx 13 software prescribing application.
- Version number of the certified EPCS software application: current stable version.
EHR providers in New York must sign up for the comprehensive version of Legacy eRx so that drug interaction checks and formulary checks are enabled when orders are created. Because the state requires e-prescribing, you will not qualify for the exclusion even if you write few prescriptions. See EHR Objective 4: ePrescribing.

Lab Case
In the Chart Module (298) toolbar, click LabCase.

Alternatively: In the Edit Appointment (20) or Edit Planned Appointment Window, click Lab in the left panel, then New.

Before creating a lab case, set up dental Laboratories (918).

- **Patient**: Patient associated with lab case.
- **Appointment**: The scheduled appointment this lab case is attached to. Click Detach to remove the association with the appointment without deleting the lab case.
- **Planned Appointment**: The Planned Appointment (325) this lab case is attached to. Click Detach to remove the association with the appointment without deleting the lab case.
- **Provider**: Provider associated to lab case.
- **Fee**: For tracking and informational purposes only. The fee is not used in any calculation.
- **Lab**: A list of labs added in Laboratory Setup. The lab’s available services and turnaround times (as set in Laboratory Setup) will list under Set Due Date.
- **Set Due Date**: A list of services and turnaround times defined in Laboratory Setup for the selected lab. The turnaround time is used to calculate a Date Time Due. After you click the turnaround time, it will not stay highlighted. Click on a service/turnaround time to automatically calculate a Date Time Due, skipping weekends and holidays (as set in Schedules). It is assumed that holidays are days that both the practice and labs will be closed. Provider schedule is not taken into account. Note that selecting a service does not track the kind of lab case, it only generates the due date. Dates can also be edited as needed.
- **Date Time Due**: If you click a service/turnaround time listed under Set Due Date, the Date Time Due will automatically calculate. You can also edit as needed. If left blank, the date time due of 01/01/0001 12:00 AM will automatically be inserted when lab slips or sheets are generated.
• **Instructions**: Instructions that will show on the generated lab slip.

• **Tracking Dates**: Used to track the progress of the lab case. Click Now to insert the current date and time. This is useful for managing Lab Cases (1245).
  - Created: When the lab case was created.
  - Sent: When the lab case was finished being packaged and set out to be picked up. It may not actually be picked up until hours later.
  - Received: When the lab case was processed by the office staff as having come back from the lab. The box does not need to be opened.
  - Quality Checked: The box has been opened. The case appears to be ready to deliver to the patient. The staff has performed whatever quality checks are needed, including checking contacts, appearance, etc.

**New Slip / Edit Slip**: Generate a new lab slip, or edit a lab slip for an existing lab case. Set default lab slips for each lab in Laboratory Setup.

Note: Only one lab case can be attached to an appointment. If you have two lab cases, make another appointment next to the first and move the procedure (e.g. seating) to the second appointment. Lab cases are associated with the clinic that is assigned to the operatory the attached appointment is scheduled in.

Once a lab case is created, an entry will be added in the Progress Notes. If it was created within the Edit Appointment or Edit Planned Appointment window, the lab case will already be attached to the appointment and is ready to be scheduled. If created outside of an appointment, see Attach a Lab Case to an Appointment below.

**Attaching a Lab Case to an Appointment**

The lab case can be attached to a planned appointment first or directly to a scheduled appointment.

To attach to a planned appointment, double-click appointment in the Planned Appts tab to open the Edit Planned Appointment Window.

To attach to an already scheduled appointment, double-click the appointment itself in the Appointments module to open the Edit Appointment Window.

Click Lab in the left panel, then select the lab case and click OK to attach it. To create a new lab case, click New.

A list of lab cases already created for this patient, but not attached to an appointment, will show.

The attached lab case information will show in the Lab field.

It will also show in the appointment itself if Lab is added to the appointment view (Appointment View Edit (622)).
Lab Slip

In the Lab Case (379) window, click New Slip.
Dental Lab Case (379) slips are a type of sheet.
- To customize a dental lab slip, see Lab Slip Layout (1162).
- To set a default slip for a dental lab, see Laboratories (918).
- Lab slips support Electronic Signatures (306).
- View a patient's lab slips in the Chart Module (298) and Account Module (150).

Pale yellow areas indicate data entry areas.

Instructions entered on a labcase automatically insert into the Instructions field when the slip is first created. If editing instructions after the slip has been generated, you must edit the instructions on both the labcase and within the lab slip.

To print or email a lab slip, click Print/Email.

By default, paper copies will be 1 and the Email to patient box will not be checked. If an email is entered for the patient, it will show. Change the settings as needed then click OK.

Perio Chart

In the Chart Module (298), click Perio Chart.
See also: Webinar: Perio Chart

**Exams:** Up to six of the most recent exams can show for easy comparison. Data from prior exams shows in gray. Current exam data shows in dark text. Probing depths show for all exams. For other measurements only the most recent data shows.

- **Show current exam only:** Only show data for the current exam. This is a user preference and will be remembered the next time the same user opens the perio chart.
- Double-click an exam to edit the date or provider.
- **Add:** Add a new perio exam.
- **Copy Previous:** Copy the last exam entered (the exam with the most recent date).
- **Delete:** Delete the selected exam.
- Click the **microphone icon** to begin recording measurements using voice commands. See **Voice Perio Charting**.

**Auto Advance:** Shows the current path direction.

- **Right and Left:** Follows the order below. When it gets to the end of an arch, it drops to a new row and the Right/Left direction changes automatically.
  - 1-16 facial
  - 16-1 lingual
  - 32-17 facial
  - 17-32 lingual
- **Custom:** Follows this path:
  - 1-16 facial
  - 17-32 facial
  - 32-17 lingual
Triplets: The triplet option is handy for entering lots of plaque, calculus, gingival margins, or any other measurements that tend to be the same for the entire tooth. When in triplet mode, the backspace key deletes three at a time and editing an existing entry will overwrite three at a time, so be careful to turn it off when done.

Types of rows:
- **Probing:** Each dated exam shows on its own row.
- **Mobility:** Only shows on the facial. Only allowed one number for each tooth in the middle cell. There is no mechanism yet to show +.
- **Furcation:** Enter 0-3. Earlier versions will show a V or a triangle instead of the numbers.
- **auto CAL:** Clinical Attachment Loss is auto calculated as Probing + Gingival Margin. Users are not allowed to edit.
- **Gingival Margin:** Gingival margins are implied negative values (recession). When the gingival margin is coronal to the CEJ, a + number can be charted in one of two ways. 1) Check the Ging Marg box, enter the positive value(s) using the keypad or keyboard, then uncheck the box. or 2) On your keyboard, press Ctrl + the number (Ctrl + 3 = +3).
- **Mucogingival Junction:** This can be charted on the facial of the maxillary, and facial and lingual of the mandibular.

**Number Entry:** Press the numbers on screen or use your keyboard.
- On the screen: For numbers greater than 9, click 10 button followed by the second digit (10 + 9 = 19)
- On your keyboard: For numbers greater than 9, press Ctrl + the second number (Ctrl + 3 = 13). Backspace and Delete work as normal.
- A string of alphanumerical characters entered in a different text editor can also be copy and pasted into the grid (e.g. 1B1211C22S...), using ctrl-V.

**Plaque, Calculus, Bleeding, and Suppuration:** Enter using the on-screen button, or a keyboard letter P, C, B, or S. These are entered on the same rows as the probing depths. They show as colored dots above each probing number. There is room for all four colored dots to show. You can enter as you chart probing depths or separately. If entering at the same time as the probing depths, enter the probing depth first (e.g. 5-bleeding). When you enter the probing depth, you will automatically advance to the next cell, but if the cell is empty, the program knows to enter the item on the previous probing entry. Customize colors for each by clicking the color boxes on the right.

**Calc Index %:** Click to recalculate the four index percentages. Typically there are 6 sites per tooth and 32 teeth, for a total of 192 possible sites. Example: If you have 19 of the 192 sites marked as bleeding, the bleeding index is 10%. Teeth marked skipped are not considered available and are excluded from the calculation.

**Numbers in Red:** Flag measurements in the grid with red text when greater than or less than a certain value.
- **Red if:** Click the up/down arrows to change the value. For Probing, Ging Marg, CAL, Furc, and Mobility, measurements will be flagged red when they are greater than or equal to the value. For MGJ, measurements will be flagged red when less than or equal to the value. The main concern here is that it show sites with little or no attached gingival.
- **# Teeth:** For each row, shows the number of teeth that are marked in red. The printout will actually list out all the tooth numbers.
- **Count Teeth:** Click to refresh tooth counts.

**Skip Teeth:** Select teeth to mark as skipped when perio charting. Set default options for how to handle missing teeth in Chart Module Preferences(706).
- **Perio exams always skip missing teeth:** Determines if new missing teeth are automatically skipped in new perio exams.
- **Perio exams treat implants as not missing:** Determines whether or not teeth with implant procedure codes (paint type of 'implant') are considered missing.

These two preferences work together, so if implants are treated as missing, and missing teeth are always skipped, the implants will be skipped.

- The perio exam will never start on a tooth marked missing.
- Missing teeth that will be skipped are indicated with a gray background, but you can still record measurements if you wish.
- Skipped teeth are automatically skipped during auto advance.
• Skipped teeth are stored with individual perio exams, so each exam can have different teeth skipped.
• Teeth marked skip in a previous exam are automatically marked skip in the next exam.
• To manually mark teeth as skip, select the teeth then click SkipTeeth. To unmark a tooth as skip, select the tooth then click SkipTeeth again.
• Teeth with implants are indicated on the perio chart with an i (e.g. 17i).

**Graphical:** See *Graphical Perio Chart*(385).

**Save to Images:** Save the current perio chart to the Images module, Tooth Charts folder, named by date.

**Print:** Print the perio chart as it appears on the screen.

Note: There can be some complex situations with extra teeth. This can happen with supernumerary teeth and retained deciduous teeth. If there is no way to enter this information into the existing boxes, notes can be made about specific sites in the Progress Notes.

**Graphical Perio Chart**

In the *Perio Chart*(382), click Graphical.
The graphical perio chart is a way to view a full screen 3D image of the patient's Perio Chart. Your Graphics Preferences must be set to Direct X Tooth Chart.

**Implants:** Teeth with implants are indicated with the implant graphic.

**Setup Colors:** Click to select measurement colors.
**Save to Images**: Save the graphical image to the Tooth Charts folder in the Images module.

**Print**: Print the graphical image as it appears.

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**Voice Perio Charting**

In the **Perio Chart** (382), click the **microphone icon** to start recording.

The chart can be recorded via voice commands in English, using Universal Tooth Numbering. A microphone must be set up on the computer. Any microphone or headset recognized by Windows will work.

Use the following list of voice commands when voice charting. These are the only prompts Open Dental will recognize.
Adding Exams:
- **Add perio exam**: Add a new exam.
- **New perio exam**: Add a new exam.
- **Copy previous exam**: Copy the previous exam.

Navigating the Perio Chart:
- **Stop Listening**: Pause listening. Useful when you need to chat with patient.
- **Start Listening**: Start the listening. Used to restart listening after having paused it.
- **Stop giving feedback**: Turn off system from repeating measurements.
- **Start giving feedback**: Turn system back to repeat measurements.
- **Left**: Move cursor left.
- **Right**: Move cursor right.
- **Delete**: Delete selected item.
- **Backspace**: Move cursor back a space and clears the newly selected cell.
- **Skip tooth** &lt;say tooth #&gt;: Skip selected tooth.
- **Skip current tooth**: Skip currently selected tooth.
- **Probing**: Move cursor back to probing.
- **Check triplets**: Check the box for Triplets.
- **Uncheck triplets**: Uncheck the box for Triplets.
- **Triplets**: Toggles triplets box.
- **Resume Path**: Place cursor in the first empty probing position.

Selecting Teeth:
- **Go to tooth** &lt;say tooth #&gt; **facial**: Move cursor to selected tooth on facial side.
- **Go to tooth** &lt;say tooth #&gt; **lingual**: Move cursor to selected tooth on lingual side.
- **Go to tooth** &lt;say tooth #&gt; **mesial** &lt;say facial or lingual&gt;: Move cursor to selected tooth on mesial lingual, or mesial facial side.
- **Go to tooth** &lt;say tooth #&gt; **distal** &lt;say facial or lingual&gt;: Move cursor to selected tooth on distal lingual, or distal facial side.
- **Select tooth** &lt;say tooth #&gt;: Move cursor to selected tooth. Whichever surface was previously selected, will be selected with the current tooth.
- **Select** &lt;say tooth #&gt;: Move cursor to selected tooth. Whichever surface was previously selected, will be selected with the current tooth.
- **Select** &lt;say tooth #&gt; **facial**: Move cursor to selected tooth on facial side.
- **Select** &lt;say tooth #&gt; **lingual**: Move cursor to selected tooth on lingual side.
- **Select** &lt;say tooth #&gt; **mesial** &lt;say facial or lingual&gt;: Move cursor to selected tooth on mesial facial or mesial lingual side.
- **Select** &lt;say tooth #&gt; **distal** &lt;say facial or lingual&gt;: Move cursor to selected tooth on distal facial or distal lingual side.

Charting:
- **Zero through nineteen**: Available probing depths.
- **Plus** &lt;say 1-9&gt;: Add depths greater than 9.
- **Mark bleeding**: Mark selected site as having bleeding on probing.
- **Bleeding facial**: Will put a bleeding mark on the facial surface of the current tooth.
- **Bleeding lingual**: Will put a bleeding mark on the lingual surface of the current tooth.
- **Bleeding mesial**: Will put a bleeding mark on the mesial surface of the currently selected side (facial/lingual) of the selected tooth.
- **Bleeding distal**: Will put a bleeding mark on the distal surface of the currently selected side (facial/lingual) of the selected tooth.
- **Mark calculus**: Mark selected tooth surface as having calculus.
- **Calculus facial**: Will put a calculus mark on the facial surface of the current tooth.
- **Calculus lingual**: Will put a calculus mark on the lingual surface of the current tooth.
- **Calculus mesial**: Will put a calculus mark on the mesial surface of the currently selected side (facial/lingual) of the selected tooth.
- **Calculus distal**: Will put a calculus mark on the distal surface of the currently selected side (facial/lingual) of the selected tooth.

- **Suppuration**: Mark selected site as having suppuration.
- **Suppuration facial**: Will put a suppuration mark on the facial surface of the current tooth.
- **Suppuration lingual**: Will put a suppuration mark on the lingual surface of the current tooth.
- **Suppuration mesial**: Will put a suppuration mark on the mesial surface of the currently selected side (facial/lingual) of the selected tooth.
- **Suppuration distal**: Will put a suppuration mark on the distal surface of the currently selected side (facial/lingual) of the selected tooth.

- **Plaque**: Mark selected tooth surface as having plaque.
- **Plaque facial**: Will put a plaque mark on the facial surface of the current tooth.
- **Plaque lingual**: Will put a plaque mark on the lingual surface of the current tooth.
- **Plaque mesial**: Will put a plaque mark on the mesial surface of the currently selected side (facial/lingual) of the selected tooth.
- **Plaque distal**: Will put a plaque mark on the distal surface of the currently selected side (facial/lingual) of the selected tooth.

- **Furcation**: Move cursor to record furcation.
- **Furcation facial**: Will put a furcation mark on the facial surface of the current tooth.
- **Furcation lingual**: Will put a furcation mark on the lingual surface of the current tooth.
- **Furcation mesial**: Will put a furcation mark on the mesial surface of the currently selected side (facial/lingual) of the selected tooth.
- **Furcation distal**: Will put a furcation mark on the distal surface of the currently selected side (facial/lingual) of the selected tooth.

- **Gingival margin**: Move cursor to record gingival margin.
- **Gingival margin facial**: Will put a gingival margin mark on the facial surface of the current tooth.
- **Gingival margin lingual**: Will put a gingival margin mark on the lingual surface of the current tooth.
- **Gingival margin mesial**: Will put a gingival margin mark on the mesial surface of the currently selected side (facial/lingual) of the selected tooth.
- **Gingival margin distal**: Will put a gingival margin mark on the distal surface of the currently selected side (facial/lingual) of the selected tooth.

- **Mobility**: Move cursor to record mobility.
- **Mobility facial**: Will put a mobility mark on the facial surface of the current tooth.
- **Mobility lingual**: Will put a mobility mark on the lingual surface of the current tooth.
- **Mobility mesial**: Will put a mobility mark on the mesial surface of the currently selected side (facial/lingual) of the selected tooth.
- **Mobility distal**: Will put a mobility mark on the distal surface of the currently selected side (facial/lingual) of the selected tooth.

- **Mucogingival junction**: Move cursor to record MGJ.
- **Mucogingival junction facial**: Will put a mucogingival junction mark on the facial surface of the current tooth.
- **Mucogingival junction lingual**: Will put a mucogingival junction mark on the lingual surface of the current tooth.
- **Mucogingival junction mesial**: Will put a mucogingival junction mark on the mesial surface of the currently selected side (facial/lingual) of the selected tooth.
- **Mucogingival junction distal**: Will put a mucogingival junction mark on the distal surface of the currently selected side (facial/lingual) of the selected tooth.

Click the **microphone icon** to end recording.

**Recommendations**
When considering which headset to purchase, choose one with good noise cancellation built-in to filter out background noise. Keep in mind that a noisy environment or improper microphone setting on the computer will result in less reliable voice recognition.

The Logitech H390 wired headset has been tested by Open Dental and has worked well for us.

**Voice controlled charting using other programs**
Perio charting can also be controlled by voice using third party programs. Below are known solutions.

- **Dragon Naturally Speaking**
- **Florida Probe Bridge** (1003)
- **Dental R.A.T.**

**Troubleshooting**

*Error: Unable to initialize audio input. Try plugging a different microphone into the computer.*

*Solution: No microphone was recognized by the computer. Check your windows microphone settings.*

**Ortho Chart**

In the [Chart Module](298) toolbar, click Ortho Chart.

![Ortho Chart](image)

The Ortho Chart can be used to keep track of orthodontic visits in a grid format. The data in the grid only shows here and is completely separate from information in the regular patient chart. This feature can also be adapted for other purposes unrelated to orthodontics.

- Only users with the **Ortho Chart Edit** security permission can enter ortho chart information or [Electronic Signatures](306).

**Setup:** Use of the Ortho Chart requires substantial setup. See [Ortho Chart Setup](392).

The information that shows depends on what you have set up.

- **Patient Fields:** See [Patient Fields](687).
- **Ortho Info:** Patient [Ortho Case](275). Only shows if the option is turned on in Ortho Setup.
- **Tabs:** See [Ortho Chart Setup](392), Add Tabs.
- **Columns:** See Ortho Chart Setup, Add Columns to a Tab.
- **Signature Box:** Only shows if a signature column has been defined in Ortho Chart Setup.
All ortho chart entries are sorted by date (oldest to newest). When a tab is opened, only date entries with data in them will show. Entering data on one tab populates all tabs with that date and data if columns are the same.

The current date always shows as a new row and the grid automatically scrolls to the most recent entry.

Double click the Patient Fields row to enter information. A list of selectable options will show for pick list fields.

To enter ortho chart information, select an ortho chart tab, then click in a cell. Cells will accept text or allow selection from a pick list. To add Auto Notes to a cell, highlight the cell, then click Auto Note.

(optional) If a Signature Box shows, electronically sign the highlighted entry, or add an electronic signature stamp for the person currently logged in. Allow digital signatures must be turned on in Chart Module Preferences. Click OK to save.

Add an Entry for a Previous Date
On the Ortho Chart window, click Add Date.

Enter the date (MM/DD/YY).

Click OK. A new row will show in the Ortho Chart grid.

Print the Ortho Chart
Click Print to print the ortho chart grid exactly as it shows when print is clicked. Print in landscape if necessary to fit all columns. In the printout header, the title of the Ortho Chart will display first. The first tab in the list determines the title. The selected tab's title will display beneath that.

Audit Trail
Use the Audit Trail to view historical changes made on a dated entry. Both patient field and ortho chart changes are tracked. To see changes for a specific date, highlight the date under Date Service. By default, all dates are highlighted when the audit trail is opened, making all changes visible.

Electronic Signature Validity
Validity of electronic signatures is determined by Open Dental. Entries with a valid signature are highlighted green and Valid shows in the signature column. Invalid signatures will turn the row red and the signature column will display Invalid. Signatures may be invalidated by:
- Changing the patient name.
- Changing any data in the signed row.
Ortho Chart Setup

In the Ortho Chart(390), click Setup.

Before entering information in the Ortho Chart(390), there are a few setup steps. The information defined during setup affects the tabs, columns, and info that shows in the ortho chart.

- Create Patient Fields(687). This information will show in the upper right of the ortho chart.
- To show Ortho Case(275), check Show ortho case information in the ortho chart in Ortho Setup(927).
- Define Ortho Chart tabs. Tabs can be useful to organize information.
- Define the columns of information that show in the Ortho Chart.

Add Tabs

Tabs are a way to organize ortho chart information. By default, there is one tab labeled Ortho Chart, but you can add many. Each tab can have the same or different columns showing.
• Note: The name of the first tab determines the text on the Ortho Chart button in the Chart module toolbar and the text of the Go to Ortho Chart right-click option when clicking on an appointment in the Appointments module.
• When there are multiple tabs, the Ortho Chart button in the toolbar will include a dropdown for each tab.

In Ortho Chart Setup, click **Setup Tabs**.

Click **Add** to create a new tab or double click an existing tab name to edit.

Enter the tab name then click **OK**.

To remove a tab, mark it as Is Hidden.

To reorder tabs, use the up/down arrows.

**Add Columns to a Tab**
The columns that show on an ortho chart tab are also set in **Display Fields** (900). Columns can allow text entry, offer selection from a pick list, or show a signature box.

On the Setup Display Fields window, click the Tab dropdown and select the tab.
The fields listed under Fields Showing reflect the columns that will show for the tab. The fields listed under Available Fields are options that are not currently showing.

Add or remove columns as needed.
• To add a field option that already exists, highlight it under Available Fields then click the left arrow.
• To add a field name that is not listed, enter the description in the New Field box then click the left arrow.
• To remove a field, highlight it under Fields Showing then click the right arrow.

Note: A field is deleted when it is moved into Available Fields for every tab.

To edit a column name, customize width, or create pick list options, double-click the field under Fields Showing.
**Display Name and Internal Name**: Use these fields together to have columns’ display names appear the same (e.g. Notes and Notes) but contain different information that is not duplicated across all tabs. Otherwise, just enter an Internal Name.
- **Display Name** (optional): If entered, only this name shows on the column in the ortho chart grid. Display name overrides internal name on the ortho chart grid. Display Name will not show in Available Fields.
- **Internal Name**: This name shows in the Fields Showing grid, and on the column in the ortho chart grid if a display name is not entered. Changing the internal name on an existing field that contains data creates a new field with the new name which does not contain data. The original field moves into Available Fields and retains the original data.

**Minimum Width**: A fixed minimum column width based on the length of the name(s).

**Column Width**: Enter the actual width of the column. If the minimum width is more than the column width, adjust the column width to match for best visual results.

**Check to show signature box in the Ortho Chart**: Only check if this column is for an Electronic Signature (see below). It will add a signature box to the ortho chart and this column will indicate when an electronic signature is valid.

**One entry per line**: Add options for a pick list or leave blank to allow text entry. If creating a pick list, when a user clicks on a cell in this column, a dropdown list of all options will show. Enter one selection item per line. Use the up and down arrows to reorder items.

Click **OK** to save.

**Add a Signature Box to the Ortho Chart**
To add **Electronic Signatures** to the Ortho Chart, add a signature column to at least one ortho chart tab. Only one column can be set as a signature.

1. Select the tab.
2. Create a new field for the signature (e.g. Signature) and click the left arrow to add it to Fields Showing (if one doesn’t already exist).
3. Double click the signature field.
4. Check **Check to show signature box in the Ortho Chart**.
5. Click OK to save.
### Consent Form

In the [Chart Module](298) toolbar, click Consent.

<table>
<thead>
<tr>
<th>Display Name</th>
<th>(optional)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internal Name</td>
<td>Signature</td>
</tr>
<tr>
<td>Minimum Width</td>
<td>59</td>
</tr>
<tr>
<td>(based on text above)</td>
<td></td>
</tr>
<tr>
<td>Column Width</td>
<td>100</td>
</tr>
<tr>
<td>(this tab only)</td>
<td></td>
</tr>
</tbody>
</table>

- ✔ Check to show a signature box in the Ortho Chart.
Consent forms can be generated from the Chart Module.

- To customize layout or content, see Consent Form Layout(1156).
- View patient consent forms in the Chart Module, Progress Notes and Account Module(150).
- Consent forms can be sent to the eClipboard when Mobile Layout(1127) is enabled.

If only one consent form exists, it will generate. If more than one consent form exists, click the dropdown, then select the correct form. Above is the internal extraction consent form.

Fill out the form. Pale yellow areas indicate input areas. Electronic Signatures(306) are supported.

Click Print/Email to print or send the consent form.
By default, paper copies will be 1 and the **Email to patient** box will not be checked. If an email is entered for the patient, it will show. Change the settings as needed then click OK.

**Exam Sheet**

In the Chart Module(298) toolbar, click Exam Sheet.

Exam sheets are used to track findings during exams. Users can create multiple exam sheets and customize them with their own layout and content.

Exam sheets for a patient can be generated in the patient's Chart Module(298).

- To customize exam sheets see Exam Sheet Layout(1161).
- Exam sheets support Electronic Signatures(306).
- Completed patient exam sheets can be viewed in the Chart module, Progress Notes and Account module.
The Exam Sheets grid is a dated log of any exam sheets that have already been created for this patient.

- **Setup:** Click to quickly jump to Sheet Setup to add or customize exam sheets.
- **Show Types Filter:** Filter the grid by sheet type.

Click **Add** to create a new exam sheet.

Sheets with a type of Exam Sheet will list.

Double-click on an exam sheet to open, then fill the sheet out. Pale yellow areas indicate data entry areas. Below is an example of the internal Exam Sheet.
Note: Exam sheets can remain open while working in other windows. If changes are made to the exam sheet by another user while the sheet is open, the last user to click OK will be prompted to overwrite the other user's changes or cancel the current changes.

Print/Email: Print and email the exam sheet. By default, paper copies will be 1 and the Email to patient box will not be checked. If an email is entered for the patient, it will show. Change the settings as needed then click OK.
Create PDF: Save a PDF copy of the exam sheet to the computer.

Print: Print a copy of the Exam Sheet.

Email: Attaches exam sheet to an Email (1656) to send from Open Dental.

Delete: Delete this exam sheet.

Save: Click to save changes while keeping the sheet open.

Ok: Click to save changes and close the sheet.

Cancel: Click to cancel out of sheet without saving changes.

EHR Dashboard

The EHR dashboard is a central location for entering patient data for EHR meaningful use reporting. During a patient visit, open the dashboard to quickly enter data for objectives and measures. You can also view reports for a specific provider and reporting period.

Note: Beginning with the EHR reporting period in Calendar Year 2019, participants in the Promoting Interoperability (PI) Programs are required to use 2015 edition certified electronic health record technology (CEHRT). Open Dental has decided not to develop a certified 2015 edition software.

Select a patient. In the Chart Module (298), click EHR.
There are three different dashboards options, each based on the current setting for stage of meaningful use. See Setting your Meaningful Use Stage(440).

**Provider for this patient:** The patient's primary provider. For reporting purposes, it should be a provider with an EHR Annual Provider Key.

**Provider logged on:** The provider/user currently logged on to Open Dental.

""" for this patient: An indicator of patient data that needs to be entered. As you enter data that meets MU criteria, the rows may turn green.

- **Measure Type:** The measure / objective / task.
- **Details:** Briefly identifies entered or missing information.
- **Click to Take Action:** Click in the cell to enter data. For measures that do not require calculation, click **Edit Explanation** to type information for your own record keeping.
• Related Actions: Click in the cell to enter data for actions related to the measure.

Note: Do not rely on this grid to track your MU progress; it is merely a guide. This grid does not take into account date ranges or per-patient rules.

Reports and Percentages
To generate reports that track meaningful use progress and to use for EHR attestation, use the two buttons in the upper right.

Measure Calc: Generate a report of measure percentages. The report will include denominators, numerators, and percentages for a specific provider and reporting period. See Measure Reports.(434).

Quality Meas: Generate a report that details clinical quality measure (CQM) percentages. The report will include denominators, numerators, and percentages for a specific provider and reporting period. See Reporting CQMs(417).

Other Buttons
Hash / Encryption: Only included for 2011 certification.

Vaccines: Click to enter immunizations administered to patients and export the data as an HL7 XVU message. Since vaccines are typically outside the scope of dental practices, providers may qualify for an exclusion.

CQM related:
• Encounters: View the encounters used for CQM denominators. These can be automatically generated using default encounter codes or manually added/edited.
• Interventions: View interventions that have been documented (these affect the numerator of some CQMs). These are usually documented when entering patient vital signs or smoking status, but can also be manually added/edited.
• Not Performed: Document and view reasons an intervention or action was not performed.

Edit Events: Edit the date of measure events. The EHR Measure Event Edit permission is required.

Care Plans: Treatment plan guidance for another provider.

Clinical Summ: Open the Clinical Summary window to generate clinical summaries.

Patient List: Generating a Patient List.(442).

EHR Medical Lab Order (CPOE)

Medical lab orders can be entered in Open Dental and the results can be imported or entered directly. For an order to count for the EHR measure CPOE Laboratory Orders, a provider must be logged on when the order is created.

1. From the EHR Dashboard (400), click Edit labs.

Only orders entered after December 31, 2013 show. To view prior orders, click Labs/Rads on the EHR dashboard.

2. Click Add.

3. Enter the order information then click Save.
   - Required fields for a CPOE Lab Order:
     - Ordering Provider: Identifier, ID, Identifier Type, Universal ID. Click [...] to select a provider and auto-populate
provider information. If the provider has an NPI, the default Identifier will be the NPI number. If the provider does not have an NPI, the Provider Number (OID) is the default. Identifier must be the NPI or Provider Number.

- **Service Identifier**: Code System, Observation ID and Date/Time Start. Click [...] to select the LOINC code for this order.

Date/Time Start must be entered using this format: YYYY-MM-DD.

- **Other Fields:**
  - Place Order Number: To auto create order numbers, check the Auto box. Object Identifiers (OIDs) must be set up. The Place Order ID number should exactly match the identifying number on the lab order being sent to the lab.
  - **Last Update**: This date reflects the last time results changed and affects the date of the order on the Lab Orders window. It is not updated automatically.
  - **All Dates**: Must be entered using this format: YYYY-MM-DD
  - **TQ1 Dates**: TQ1 equals Timing and Quantity.
  - **Notes**: Notes about the lab. You can create new notes, or add comments to existing notes.
  - **Add Result**: Add a lab result.

If results for this lab have already been imported or entered, a line entry for each result will show. Double click to view.

---

**EHR Lab Results**

Results for medical lab orders can be imported or copied from a .txt file in HL7 format or entered manually. Entering / importing lab test results was a measure in both stage 1 and stage 2, but is no longer a reporting requirement in EHR Modified Stage 2.

**Importing or copying results from an HL7 .txt file**

Open Dental will attempt to identify the patient from the lab result information and match the results with an existing Lab Order. If the order doesn't yet exist, it will be created automatically. If a patient match is not made, you will need to manually attach the correct patient.

Option 1: If the lab results were emailed to you, and the results are sent as a .txt file attachment in HL7 format, they can be imported from email:

1. Open your email inbox.
2. Open the email message, then double-click on the txt attachment. If the file is properly formatted, the lab results will be parsed and attached to the lab order.

Option 2: Copy the HL7 message and import the results.

1. Copy the received HL7 message to the clipboard (select all and press Ctrl + C).
2. On the EHR Dashboard (400), click Edit Labs, Import.

3. Highlight Paste HL7 Lab Message Text Here, then press Ctrl + V to copy the results from the clipboard.
4. Click OK.
**View Results**: Open the original lab order. On the Lab Order Edit (403) window, under Lab Results, a line item for the results should list. Double click to view.

**Entering results manually**
1. On the EHR Dashboard, click **Edit labs**. Double click on the original Lab Order.
2. On the right, click **Add Result**.

3. Enter the results and click OK to save.

Note: To count towards the numerator for EHR CPOE Lab Results, the following information is required:
- Observation Value Type must equal Structured Numeric or Numeric.
- Must have a Code System/Element ID or Alt Code System/Alt Element ID, and it must a SNOMED CT code.

---

**EHR Lab Order RAD codes**

Lab orders for RAD codes (radiology orders) can be manually entered using the lab order interface and imaging results can be attached. This is an older method of entering CPOE radiology orders, but still valid. To be considered a radiology order the Service Identifier (LOINC Codes(728)) must have a class type of **RAD**. For an order to count as CPOE, a provider must be logged on when the order is created.

Note: In version 15.4 and greater there is a different and simpler way to enter and approve CPOE radiology orders for EHR.
1. From the **EHR Dashboard** (400), click **Edit labs** (403).

   Only orders entered after December 31, 2013 show. To view prior orders, click Labs/Rads on the EHR dashboard.

2. Click Add.

3. Enter required order information.
   
   **Ordering Provider:** Identifier, ID, Identifier Type, Universal ID.
   
   Click [...] to select a provider and auto-populate provider information. If the provider has an NPI, the default Identifier will be the NPI number. If the provider does not have an NPI, the Provider Number (OID) is the default. Identifier must be the NPI or Provider Number.
   
   **Service Identifier:** Code System, Observation ID and Date/Time Start.
   
   Click [...] to select the LOINC code for this order. The code must have a class type of RAD. For example, bitewings use the code 46386-9. Date/Time Start must be entered using this format: YYYY-MM-DD.
Or, some dental related LOINC codes that might be useful include:

<table>
<thead>
<tr>
<th>LOINC</th>
<th>Name Short</th>
</tr>
</thead>
<tbody>
<tr>
<td>46386-9</td>
<td>Teeth XR Bitewing</td>
</tr>
<tr>
<td>24695-9</td>
<td>Face XR</td>
</tr>
<tr>
<td>24829-6</td>
<td>Mandible XR Panorex</td>
</tr>
<tr>
<td>24829-4</td>
<td>Mandible XR</td>
</tr>
<tr>
<td>24834-4</td>
<td>Nasal bones XR</td>
</tr>
<tr>
<td>24902-9</td>
<td>Salivary gland Flr W contr intra SD</td>
</tr>
<tr>
<td>24916-9</td>
<td>Sinuses XR</td>
</tr>
<tr>
<td>24917-7</td>
<td>Skull XR 1V</td>
</tr>
<tr>
<td>25000-1</td>
<td>TMJ XR</td>
</tr>
<tr>
<td>25074-6</td>
<td>Zygomatic arch XR</td>
</tr>
<tr>
<td>26067-9</td>
<td>Salivary gland-Bi Flr W contr intra SD</td>
</tr>
<tr>
<td>26068-7</td>
<td>Salivary gland-L Flr W contr intra SD</td>
</tr>
<tr>
<td>26069-5</td>
<td>Salivary gland-R Flr W contr intra SD</td>
</tr>
<tr>
<td>26172-7</td>
<td>Zygomatic arch-Bi XR</td>
</tr>
<tr>
<td>26173-5</td>
<td>Zygomatic arch-L XR</td>
</tr>
<tr>
<td>26174-3</td>
<td>Zygomatic arch-R XR</td>
</tr>
<tr>
<td>37303-5</td>
<td>Face+Zygomatic Arch XR</td>
</tr>
<tr>
<td>37338-1</td>
<td>Skull+Face+Mandible XR</td>
</tr>
<tr>
<td>37545-9</td>
<td>TMJ-BI XR Open+Closed Mouth</td>
</tr>
<tr>
<td>38153-3</td>
<td>Submandib gland Flr W contr intra SD</td>
</tr>
<tr>
<td>42460-6</td>
<td>Submandib gland-L Flr W contr intra SD</td>
</tr>
<tr>
<td>43533-9</td>
<td>Mandible-R XR</td>
</tr>
<tr>
<td>43534-7</td>
<td>Mandible-L XR 4V</td>
</tr>
<tr>
<td>48491-5</td>
<td>TMJ-L XR Open+Closed Mouth</td>
</tr>
<tr>
<td>48695-1</td>
<td>Skull.base XR 1V</td>
</tr>
<tr>
<td>48696-9</td>
<td>Submandib gland-R Flr W contr intra SD</td>
</tr>
<tr>
<td>48698-5</td>
<td>Submandib gland-BL Flr W contr intra SD</td>
</tr>
<tr>
<td>48699-3</td>
<td>TMJ-UI XR Open+Closed Mouth</td>
</tr>
</tbody>
</table>

To determine which other codes are RAD, you can use this Query:

```
SELECT * FROM loinc WHERE classtype="RAD";
```

4. Enter other information if desired (optional).
   - Place Order Number: Object Identifiers (OIDs) must be set up. To auto-create order numbers, check the Auto box. When you click Save, the ID, Identifier, and Universal ID fields will populate. The Place Order ID number should exactly match the identifying number on the lab order being sent to the lab.
   - Last Update: This date reflects the last time results changed and affects the date of the order on the Lab Orders window. It is not updated automatically.
   - All Dates: Must be entered using this format: YYYY-MM-DD
   - TQ1 Dates: TQ1 equals Timing and Quantity.
   - Notes: Notes about the lab. You can create new notes, or add comments to existing notes.

5. Click Save to close the window. The denominator and numerator for CPOE_RadiologyOrdersOnly should increase by one. Measure details are visible in Stage 2 measure reports.

6. To track the imaging results, you have two options:
   - If you will send the order off and wait for results, reopen the order, click Manage Images, then check the Waiting for Images checkbox.
If/when the images are ready, reopen the order, click Manage Images, then attach them to the order. See Imaging Results.

**Troubleshooting**

The dates of orders on the Lab Orders window are all 01/01/0001. This date matches the Last Update date entered on the Lab Order Edit window. Change it as needed.

---

**EHR Attach Image to Radiology Order**

This information applied to EHR Stage 2.

See [2019 Program Requirements - Medicaid](#) for current EHR/PI information.

Imaging results (x-rays) can be attached to CPOE radiology orders.

Note: Attaching imaging results to radiology orders was a menu measure for EHR stage 2, but is no longer a reporting requirement for EHR Modified Stage 2.

---

**Waiting for images**

If a radiology order is awaiting results, you can flag the order. On the Lab Order Edit window, click Manage Images, then check Waiting for Images. This affects the denominator of the EHR imaging results measure. See [EHR Medical Lab Order (CPOE)](#).

---

**Attach images**

1. The image must first exist in the patient's [Images Module](#). Images can be imported or scanned.
2. On the EHR Dashboard for Stage 2, click Manage Images.
3. Double click the original radiology order.
4. Click Manage Images.
All image files in the Images module will list under Available Images. Click on a row to preview an image.

5. Click the **Attached column** of an image row to attach the image to this order. An X will show.
6. If **Waiting for Images** is checked, click to clear it.
7. Click OK, then Save.

The numerator of the Lab Images menu measure should increase by 1.

---

**EHR Viewing, Downloading, Transmitting Health Information**

See [EHR Dashboard](400).

In **EHR Modified Stage 2**, the second measure of the objective **Patient Electronic Access** states that at least one patient must (or authorized representatives) use the **Patient Portal Feature** to view, download or transmit to a third party their health information. In 2015, this is a requirement only for providers who would have attested to Stage 2 in 2015.

To view, download, or transmit health information, a patient will do the following:

1. In an internet browser, log in to the patient portal using the username and password supplied by the office. See [Patient Portal: What Patient Sees](1572).
2. In the portal, click Care Summary. This action counts as 'view' and changes the numerator.
History: View a detailed history of any actions that have been taken, including any taken by an authorized representative on behalf of the patient.

Download: Download a CCD as a zip file.

Transmit: Send the Summary of Care to another provider you have been referred. This button will only show in the following circumstances:
1. A referral has been entered in Open Dental.
2. The referral uses Direct Messaging. This will be rare. 'Email Trust for Direct' must be checked on the Add Referral window for the referral provider.

When Transmit is clicked, if the referral's public key certificate already exists in the local certificate store, the message will be sent. If it does not yet exist, a query attempts to discover the referral's public certificate key, and if found, downloads it to the local certificate store. If successfully downloaded, the host computer will proceed with transmitting the summary of care. If the certificate download fails, the patient will be prompted to contact their provider.

EHR CDS Interventions
See EHR Dashboard(400).

CDS interventions provide evidence-based clinical guidance when a user is making a clinical decision. If a user has the appropriate EHR CDS Permissions(731) and enters data for a patient that triggers a CDS Rule(729), an intervention will pop up on-screen.
Each intervention identifies the conditions that triggered it, as well as instructions and bibliographical information.

Info button: Shows when a user has the Show i CDS Permission. Click this button to access additional clinical information via MedLinePlus. See EHR InfoButton(428).

Click OK to close the intervention.

Click Cancel Current Action to cancel the addition of the data that triggered the intervention. This option is not available for all interventions.

EHR Educational Resources
On the EHR Dashboard(400), click Provide education resources.
To provide an education resource, the patient must meet criteria that triggers a resource.

- See Setting up Education Resources and Triggers (722).
- For EHR measure details, see EHR Objective 6: Patient-Specific Education.

All education resources triggered based on this patient's problems, medications, lab results, or tobacco status are listed at the top.

Click on a link to open a resource in a browser window.

Click Print, then provide the resource to the patient. A dated log entry will list under Education Provided and the numerator in Measure Reports for Education will increase.

**EHR Amendments**

Amendments are a way to document and track provider, organization, or patient provided information in the patient's EHR record. You can scan documents or only document a file's location. Scanned amendments do not show in the patient's chart, in the Images module, or anywhere else.

On the EHR Dashboard (400), click Amendments.
Double click an existing amendment to edit, or click **Add** to enter a new amendment.

**Date Requested**: Date the amendment was requested.

**Date Accepted/Denied**: Date that you accept or deny the request.

**Date Appended**: Date the document was scanned. This date is automatically populated when a document is scanned.

**Status**: The current status of the amendment.

**Source**: Who made the request or provided the document (provider, patient, organization, other).

**Source name**: The name of the source.

**Description/Location**: If scanned, enter a description of the document. If not scanned, enter a description and where it is stored.

**Scan**: Scan the document. If scanned, the button will change to View. Documents can only be viewed from within the Edit Amendment window.

**Scanning/viewing a document**
Click **Scan** or **View** to launch a modified version of the Images toolbar.
The file name is listed on the left, and the scanned document can be viewed on the right. There can only be one document per amendment. Each time you scan an amendment, it will remove the old document and replace it with the new document. If you have multiple pages, use the **Multi-Page** button so the pages are recognized as one document.

- **Printer**: Print the document.
- **X**: Delete the document.
- **Scan**
  - **Document**: Use the flatbed scanner of your attached device to Scan a single page document.
  - **Multi-Page Document**: Use the automatic document feeder (ADF) of your attached device to scan multiple pages.
- **Import**: Import an existing file from your computer or network. You can only import one file at a time.
- **Export**: Export the file to another location on your computer or network.
- **Copy**: Copy the document to the clipboard.
- **Paste**: Paste an item from the clipboard into the selected image folder.
- **Magnifying Glass + and -**: Zoom in and out in 50% increments.
- **100**: View the image at 100%

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**EHR Continuity of Care Document (CCD)**

See [EHR Dashboard](#).

A Continuity of Care document (CCD) is a health record document standard used to share patient health information electronically. In Open Dental, [EHR Clinical Summary](#) and [EHR Summaries of Care](#) are sent in the CCD format.

The following information shows on a CCD.

**Patient Information**: Name, Birthday, Ethnicity, Language, Sex and Race are set on the [Edit Patient Information](#).

**Table of Contents**: Click a link to quickly jump to a category.

**Allergies and Adverse Reactions**: Medication allergies only show if, in the Allergy List(1221),

1. The allergy is associated with a medication that has an RxNorm(735), and
2. The Allergy Type is *AdverseReactionsToDrug, DrugAllergy, or DrugIntolerance*. Otherwise, the allergy is treated as an ingredient allergy (e.g. peanuts, latex), and will only show if it has a UNII code.

**Encounters**: A list of [EHR Encounters](#).

**Functional Status**: A list of patient Problems(468) that have a Problem Type of *Problem* and a Functional Status of *CognitiveResult, CognitiveProblem, FunctionalResult, or Functional Problem*. This is defined on the Edit Problem window (on the Medical window, double click a problem in the patient's list, see [Medical](#)).

**Immunizations**: A list of all [EHR Vaccine Data](#) entered.

**Instructions**: Clinical Summaries only. Shows information entered as Instructions when a clinical summary is generated.

**Medications**: A list of all medications in the [Medications](#) list (inactive and active).

**Care Plan**: A list of care plans entered on the Care Plan window.

**Problems**: All problems in the patient's Problem List (inactive and active), that have a Problem Type of *Problem* and a Functional Status of *Problem*.
**Procedures**: All procedures in the patient account which are not treatment planned and not referred out, including completed and existing procedures. The code and description that shows on the CCD is the Proc Code and Description as entered on the [Procedure Code](#) (1200).

- If the Proc Code is an CDT code, the CDT code and description show. These cannot be edited.
- If the Proc Code is a SNOMED CT (see [SNOMED CT Codes](#) (727)), the SNOMED CT code and official description (not necessarily from the Procedure Code List) show. These codes must be manually added to the Procedure Code List. See [Add Procedure Code](#) (1204).
- If the Proc Code is a five digit number (CPT code), then the CPT code and description show. These codes must be manually added to the Procedure Code List.
- If no code is specified, then the procedure will export without a code as required.

Any cross coding in the Procedure Code List does not affect the CCD (e.g. medical codes, alternate codes).

If any procedure has a SNOMED CT Body Site entered on the [Procedure - Medical Tab](#) (314), an additional Body Site column will show under Procedures on the CCD. If no body site is entered, this column is hidden.

**Reason for Referral**: This content will change based on which document is being generated/sent. The text cannot be edited.

**Diagnostic Results**: A list of Lab Results that specify Test Performed LOINC.

**Social History**: Includes the patient's smoking status and pregnancy information.

**Vital Signs**: A log of all vital signs entered for this patient

**Author**: The patient's primary provider (selected on Patient Edit window) and Practice (931) contact information.

**Custodian**: The NPI of the Practice’s default provider and the practice address and contact information. For practices with a single provider, will be the same as the author. For Clinics (1505), will probably be the NPI of the organization instead of a person.

**Legal Authenticator**: Only shows when the Practice's default provider is a person. Includes the NPI of the default provider and the practice address and contact information.

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**EHR Clinical Summary**

On the [EHR Dashboard](#) (400), click Send clinical summary to Pt.
Clinical summaries are after-visit summaries that provide relevant and actionable information and instructions to a patient. This was a measure in stage 1 and stage 2 of EHR, but is no longer a reporting requirement for EHR Modified Stage 2.

The Clinical Summaries Sent to Patient grid lists dated log entries of clinical summaries that have been provided to the patient. To preview an xml version of the CCD file, click **Show xml**.

To provide the clinical summary, you have three options:

1. (recommended) Click **To Portal** to automatically send the clinical summary to Patient Portal.
2. Click **Export** to save two clinical summary files (the document and a stylesheet) to a location on your computer.
3. Click **Show xhtml** to preview the clinical summary in a web browser. You can then Print it to paper or as a PDF file to provide to a patient.
Select and enter the information to include in the clinical summary, then click OK.

- **Visit Date:** Enter a date to limit the information to a specific office visit, or leave blank to include all information for all dates. If a date is entered, procedures, vital signs and encounters with matching dates will show, and care plans for today's date and the future will show.
- **Sections:** Check the boxes next to the information to include. Click All to select all sections; click None to clear all selections. For a detailed explanation of all areas, see [EHR Continuity of Care Document (CCD)](414). If you uncheck boxes, the heading will show and content will say *none*.
- **Instructions:** Type any instructions.

Select method:

- **If To Portal:** The clinical summary files will be sent to the Patient Portal Feature as a WebMail attachment. A patient email is not required. The provider associated with the clinical summary will be the logged in provider, or, if a provider is not logged in, the patient's primary provider.
- **If Exporting:** Select the location on your computer where the ccd.xml and ccd.xls files will be exported, then click OK. The default location is the first category/folder in the patient's *Images Module* (480). We recommend creating a new Images category in *Definitions* (835) (e.g. EHR Exports) and place it as the first category.
- **If Show xhtml:** The clinical summary will open in a browser window. Click Print.

When a clinical summary is sent to the patient portal, there is no verification that the Patient Portal has been set up or that a patient has been granted access. See [Patient Portal Access](1560). The clinical summary is sent to the portal regardless. Once the patient can access the portal, the clinical summary will be available for viewing.

**EHR Report Clinical Quality Measures (CQMs)**
We recommend checking EHR Clinical Quality Measures (CQMs) percentages early during your reporting period to make sure values are increasing.

- If denominators are 0, there are no EHR Encounters. Set a default encounter code or manually create encounters.
- If the numerator values are low, make sure you are completing the actions required. See EHR Clinical Quality Measure Descriptions.

1. On the EHR Dashboard, click **Quality Meas.**

![EHR Dashboard](image)

2. Enter the reporting period start and end dates and select the provider to report on.
3. Click **Refresh** to update the list.

A CQM may be represented by several rows if the data is divided into different classifications (e.g. divided by age groups). Double click a row to see exactly what is included in each denominator, numerator, exception, etc. See EHR CQM Calculation Details.

To export and submit the CQM data:

1. Click **Create QRDAs.**
2. Select a location on your computer to export the CQM files to, then click OK. A message will show indicating the files have been exported successfully. The file set will be grouped under a dated CQM folder in the file location.
3. Submit the report.

**EHR Clinical Quality Measures**

This information applies to
EHR Modified Stage 2 for Program Years 2015 to 2018. For current information, see:

- [EHR Modified Stage 2](#)
- [2019 Program Requirements - Medicaid](#)
- [Open Dental EHR](#)

Also see [EHR Dashboard](#).

Reporting Clinical Quality Measures (CQMs) is an EHR Modified Stage 2 requirement. CQMs are tools used to measure and track the quality of healthcare services.

Open Dental reports on 9 CQMs. These CQMs were chosen for certification because they cover at least 3 National Quality Strategy (NQS) domains, focus on high-priority health conditions and best-practices for care delivery, and are applicable to dental providers.

**Calculations**

- Denominators are based on [EHR Encounters](#). By default, encounters are not automatically generated based on completed procedures or appointments. However, you can automate the process if you set a [EHR Default Encounter Code](#). If you choose not to set a default, you must manually generate CQM encounters that are appropriate for each measure.
- Numerators are based on completing specific actions and/or [EHR Interventions](#).

For specific denominator and numerator logic for each CQM, see [EHR Clinical Quality Measure Descriptions](#).

Some CQMs use specific code systems in calculations. To download coding systems and see which codes are used in CQMs, see [Importing Coding Systems](#).

**Related links**

- How to
  - [EHR Default Encounter Code](#)
  - [EHR Default Pregnancy Code](#)
  - [EHR CQM Calculation Details](#)
  - [EHR Report Clinical Quality Measures (CQMs)](#)

- CQM-related actions
  - [EHR Attest Medications Documented](#)
  - [Enter Treatment](#)
  - [EHR Vaccine Data](#)
  - [EHR CQMs Not Performed](#)

**EHR Payor Type / SOP Codes**

Payor types are used in some [EHR Clinical Quality Measures](#) calculations. Payor types refer to the system of payment (SOP code) that identifies a patient's payor status. A patient's payor type selection may determine if a patient counts in a CQM denominator.

**Select a Patient's Payor Type**

1. In the [Family Module](#), Patient Information area, double click on the Payor Types row. (If you do not see the row, it may need to be added to Fields Showing in [Display Fields](#), Patient Information.)
A historical log of the patient's payor types will show.

2. Click Add to select a payor type, or double click a row to edit.

3. Select the payor type information, then click OK to save.
   - Start Date: Defaults to today's date
   - Payor Type: A list of all SOP codes. If the list is blank, SOP codes must be downloaded. See Importing Code Systems (726).
   - Note:
   When a new payor type is added, the Date End for the previous payor type entry (if it exists) will be the start date of the new entry.

EHR Attest Medications Documented

See EHR Dashboard (400).

For Clinical Quality Measure (421) #68, Document Current Meds, a provider must verify during a patient encounter that the patient's Medication List is current to the best of his/her knowledge and ability.

Webinar: Documenting Current Problems, Medications, and Allergies

1. In the Chart Module (298), double click on the medical information in the Patient Info area.
2. Click the Medical Info (466) tab.
3. Check a radio button under Current Meds Documented.
   - If Yes, this patient encounter will count in the numerator for this measure, thus increasing the percentage.
   - If No then OK is clicked, you will be prompted to enter a reason for EHR CQMs Not Performed(440). If a qualifying reason is entered, this encounter will be excluded from both the end denominator and numerator and not affect the percentage.
4. Click OK to save information and close the window.

EHR Clinical Quality Measure Descriptions
See EHR Dashboard(400).

The nine EHR Clinical Quality Measures(418) (CQMs) tracked and reported by Open Dental are described below. CQM denominators are based on eligible Encounters. Also see EHR Report Clinical Quality Measures (CQMs)(417).

#68 Document Current Meds
Percentage of encounters for patients aged 18 years and older for which the EP attests to documenting a list of current medications to the best of his/her knowledge and ability.

Calculation Info: Document Current Medications

- **Denominator:** Patients 18 or older at the start of the reporting period with an eligible encounter during the reporting period.
- **Numerator:** For each encounter, provider must attest that the patient's Medication List is current (Medical Window(466), Current Meds Documented). See EHR Attest Medications Documented(420).
- If a valid reason EHR CQMs Not Performed(440) is documented, the encounter will be excluded from the numerator and denominator.
#69 Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up

Percentage of patients aged 18 years and older with a documented BMI during an encounter or during the previous six months, AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the encounter.

**Calculation Info:** There are two BMI Screening and Follow-Up calculations based on age.

- **Denominator**
  - BMI Screening and Follow-Up, 65+: Patients 65 or older at the start of the reporting period with an eligible encounter during the reporting period.
  - BMI Screening and Follow-Up, 18-64: Patients aged 18 to 64 at the start of the reporting period with an eligible encounter during the reporting period.

- **Numerator:** Patients in the denominator who meet the following criteria.
  - Have height and weight entered (during encounter or in previous six months).
  - If BMI is outside of normal parameters, an intervention must also be documented. See [EHR Interventions](429).
  - If there is a documented Exclusion from BMI exam due to pregnancy, the encounter is excluded from the calculation.
  - If a valid Reason Not Performed is documented, the encounter is excluded from the calculation.

#74 Primary Caries Prevention Intervention as Offered by Primary Care Providers, including Dentists

Percentage of children, age 0-20 years, who received a fluoride varnish application during an eligible encounter in the reporting period. Calculations are divided into 4 age categories:

**Calculation Info:** There are four Caries Prevention calculations based on age.

- **Denominator**
  - Caries Prevention, 0-20: Patients 0 - 19 at the start of the reporting period with an eligible encounter during the reporting period.
  - Caries Prevention, 0-5: Patients 0 - 5 at the start of the reporting period with an eligible encounter during the reporting period.
  - Caries Prevention, 6-12: Patients 6 - 12 at the start of the reporting period with an eligible encounter during the reporting period.
  - Caries Prevention, 13-20: Patients 13 - 20 at the start of the reporting period with an eligible encounter during the reporting period.

- **Numerator:** Patients in the denominator who have a completed fluoride procedure during the reporting period (D1208, D1206, D5986).

#75 Children Who Have Dental Decay or Cavities

Percentage of children, ages 0-20, who have had a diagnosis of caries with an eligible code within the reporting period.

**Calculation Info:** Child Dental Decay, 0-20

- **Denominator:** Patients 0 - 19 at the start of the reporting period with an eligible encounter during the reporting period.
- **Numerator:** Patients in the denominator who have a [Problem](1250) with eligible [SNOMED CT Codes](727) (used by CQM 75), added to their [Problem List](468).

#127 Pneumonia Vaccination Status for Older Adults

Percentage of patients 65 years of age and older, with an eligible encounter during the reporting period, who have ever received a pneumococcal vaccine. See [EHR Vaccine Data](451).

**Calculation Info:** Pneumococcal Vaccination, 65+

- **Denominator:** Patients age 65 and older at the start of the reporting period with an eligible encounter during the reporting period.
- **Numerator:** Patients in the denominator who had a pneumococcal vaccination with qualified code administered, or a history of the vaccination documented, before or during the reporting period.
### #138 Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.

**Calculation Info: Tobacco Cessation Intervention**
- **Denominator:** Patients 18 or older at the start of the reporting period with an eligible encounter during the reporting period.
- **Numerator:** Patients in the denominator who meet the following criteria.
  - Have a smoking assessment recorded within 24 months of the reporting period end date.
  - If assessed as a tobacco user, an Intervention for tobacco cessation is documented. See EHR Interventions (429).
- If a valid Reason Not Performed is documented, the patient will be excluded from the calculation.

### #147 Preventive Care and Screening: Influenza Immunization
Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization.

**Calculation Info: Influenza Immunization, 6 months+**
- **Denominator:** Patients 6 months+ at the start of the reporting period with eligible influenza encounter between October 1 of the year before the measurement period and March 31 of the measurement period and an eligible encounter during the reporting period.
- **Numerator:** Patients in the denominator who received an influenza vaccination during the reporting period, or reported previous receipt of the vaccination during the encounter. See Enter Vaccine Data (451).
- If a valid Reason Not Performed (440) is documented, the patient will be excluded from the calculation.

### #155 Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents
Percentage of patients 3-17 years of age, who had eligible encounters during the reporting period, and who had evidence of the following:
- BMI Assessment: Height, weight, and body mass index (BMI) percentile documented.
- Nutritional Counseling
- Physical Activity Counseling

**Calculation Info:** Calculations are further categorized by age (3-17, 3-11, 12-17). Patients with a documented Exclusion from BMI exam due to pregnancy are excluded.
- **Denominators:**
  - For 3-17 measures: Patients 3 - 16 at the start of the reporting period with an eligible encounter during the reporting period.
  - For 3-11 measures: Patients 3 - 11 at the start of the reporting period with an eligible encounter during the reporting period.
  - For 12-17 measures: Patients 3 - 16 at the start of the reporting period with an eligible encounter during the reporting period.
- **Numerators:**
  - BMI Assessment: Patients in the denominator with entries of height, weight, and BMI percentile during reporting period. See Enter Vital Sign (474)s.
  - Nutritional Counseling: Patients in the denominator who had a nutritional counseling intervention documented.
  - Physical Activity Counseling: Patients in the denominator who had a physical activity intervention documented.

### #165 Controlling High Blood Pressure
Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90mmHg) during the reporting period.

**Calculation Info: Controlling High BP**
CQM numerator affected when a hypertension Problem with an eligible SNOMED CT code (used by CQM 165) is added to the patient's Problem List.
• Denominator: Patients 18-84 at the start of the reporting period with an eligible encounter during the reporting period who also have a diagnosis of hypertension in their Problem List that starts before or within the first 6 months of the start of the reporting period.
• Numerator: Patients in the denominator whose blood pressure was recorded during the most recent eligible encounter, and the results were diastolic \(<90\) mmHg and systolic \(<140\) mmHg. See Enter Vital Signs.
• If patient is pregnant the encounter is excluded from the calculation.

EHR CQM Calculation Details
See EHR Dashboard(400).

The CQMs reported by Open Dental list on the Clinical Quality Measures 2014 window(417). A CQM may be represented by several rows if the data is divided into different classifications (e.g. divided by age groups). You can drill down to the patient level for each calculation to see what is included in each denominator, numerator, exception, etc.

Double click a row to see calculation details.

Audit: EHR Encounters(425) included in the denominator, plus exclusions or exceptions.

• If Numerator = X then this encounter is included in the numerator.
• If Exclusion = X then this encounter meets exclusion criteria and is not counted in the final denominator value.
• If Exception = X, then a valid reason EHR CQMs Not Performed(440) was documented for this encounter and it is not included in the final denominator value.
Descriptions of each denominator, numerator, exception, or exclusion also show.

- **Denominator:** All patients calculated (had an eligible encounter).
- **Numerator:** All patients for whom the required action was performed (e.g. information recorded, intervention performed).
- **Exclusions:** Patients who had an eligible encounter but are excluded from the denominator for a valid reason (e.g. pregnancy). Valid exclusions vary by CQM. Pregnancy is usually documented in Vital Signs as an Exclusion from BMI.
- **Exceptions:** Patients who have a valid reason CQMs Not Performed documented for an eligible encounter. Exceptions are excluded from the performance rate calculation.
- **Performance Not Met:** The number of encounters for which CQM data was not entered. Denominator - Numerator - Exclusions - Exceptions
- **Reporting Rate:** The percentage of encounters for which CQM data was entered. Exclusions and exceptions are included in the numerator. \((\text{Numerator} + \text{Exceptions} + \text{Exclusions}) / \text{Denominator}\)
- **Performance Rate:** The final CQM percentage that is reported. This number subtracts exclusions and exceptions from the denominator before calculating the percentage. \((\text{Numerator} / (\text{Denominator} - \text{Exclusions} - \text{Exceptions}))\)

**EHR Encounters**

Encounters are used to calculate EHR Clinical Quality Measures (418). Each time you have an interaction with a patient, an encounter can be created. CQM denominators and numerators take into account eligible encounters. If no encounters are created, your CQM data values will be 0.

To generate encounters, you have three options:

**Option 1 (Recommended):** Generate encounters automatically based on a recommended a default encounter code. Set a default encounter code before your reporting period begins (see EHR Settings (711)). When a procedure is set complete, one encounter code will be automatically generated per date/patient/provider combination. There are 9 encounter codes we recommend because they are used in every measure.

**Option 2:** Generate encounter codes automatically using the Insert Encounter tool. This is usually done if you do not set the default code before the reporting period begins. See EHR Generate Encounter Codes (715).

**Option 3:** Manually create encounters with a qualified code specific to each CQM measure.

**Add an encounter manually**

1. On the EHR Dashboard (400), click Encounters.

All encounters will list, both automatically and manually created.
2. Click Add.

3. Enter the encounter information and click OK.
   - **Date**: The date of the encounter.
   - **Provider**: The provider associated with the encounter.
   - **Code**: Select a qualified code for the CQM measure. Click SNOMED CT, HCPCS, or CPT to select from an imported code system, or CDT to select a CDT code. Once selected, the code system and description will show. See [SNOMED CT Codes](#) and [CPT Codes](#).
   - **Note**: Notes about the encounter.

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**EHR Encryption**

See [EHR Dashboard](#).

This is a completely useless EHR feature which nobody will ever use. The only reason it exists is that we were required, for EHR certification, to prove that Open Dental was capable of producing a encryption and decryption using AES-128. The code that we wrote for this window will become part of some security features in the next round of EHR certification in 2013.

In the EHR Dashboard, click the Encryption button at the right.
EHR Hash

See EHR Dashboard(400).

This is a completely useless EHR feature which nobody will ever use. The only reason it exists is that we were required, for EHR certification, to prove that Open Dental was capable of producing a SHA-1 hash. The code that we wrote for this window will become part of some security features in the next round of EHR certification in 2013.

In the EHR Dashboard, click the Hash button at the right.
EHR InfoButton
See EHR Dashboard(400).

The Info Button gives a direct link to MedLine Plus where you can find additional clinical information. The Info Button only shows for users with the Show iCDS permission(731).

Click the Info Button.

This information is used to construct the message sent to MedLine Plus. Some information fields are for validation only; others are not currently used.

**Patient**: The patient (validation).

**Provider**: The patient's provider (validation).
Administrative Gender: The patient's gender (validation).

Encounter: Not currently used.

Requestor/Recipient: May affect the complexity of the information returned by MedLine Plus (for provider or patient).

Task Code: Not currently used.

Knowledge Request Form: The items entered will be sent to MedLine Plus to filter results. Only coded items will be recognized. To add an item, click Problem, RxNorm, Allergy, SNOMED CT, ICD9, ICD10, or LOINC.

Preview Request: View the message sent to MedLine Plus.

Send: Send the message and view results in MedLine Plus.

Cancel: Close the window without sending the message to MedLine Plus.

Related links
- Problem List(1250)
- RxNorms(735)
- Allergy List(1221)
- SNOMED CT Codes(727)
- ICD9(129)
- ICD-10 Codes(129)
- LOINC Codes(728)

EHR Interventions
When a provider documents an intervention for an eligible patient encounter, it counts towards EHR Clinical Quality Measures(418). Interventions are documented while entering patient EHR Vital Signs(474) and Smoking Status(455), or can be viewed and added on the Interventions window.

To view all patient's interventions, on the EHR Dashboard(400), click Interventions.
Adding interventions

1. Click Add.
2. Enter the intervention date. Today's date is the default.
3. Highlight the intervention. To filter the list by type, click the Code Set dropdown.
4. If patient declines the intervention, check Patient Declined.
5. Enter a note (optional).
6. Click OK. If you select a medication, the Medication for Patient window will open so you can enter instructions and start date. The medication will also be added to the patient's Medications List.

**Editing interventions**

Only date, patient declined, and notes can be edited.

1. Double click an intervention to open the Intervention window. Only the Date, Patient Declined checkbox and Note field will be active. The current intervention will be highlighted.
2. Make changes as needed.
3. Click OK.

To delete an intervention, click Delete on the Intervention window.
EHR Edit Measure Events

Measure events are actions a user takes that affect an EHR measure calculation. Measure event dates can be changed. All changes are tracked in an audit trail. You must have the EHR Measure Event Edit Permission. See Permissions(1118).

Change a measure event date

To edit a measure event, select a patient.

1. In the Chart Module(298) toolbar, click EHR. The stage 1 or stage 2 dashboard(400) will show depending on your Meaningful Use stage.

2. Click Edit Events.
All measure events will list for the date range, sorted by date, newest to oldest.
  o To filter by measure event type, click the Type drop down and select an option.
  o To change the date range, enter a new start or end date, and click Refresh.

3. Double click an event type to edit.

4. Change the date/time as needed. Notes are optional. Click OK.

Audit trail
All changes to measure event dates are tracked in an Audit Trail (1424). On the EHR Measure Events window, click Audit Trail.
**EHR Measure Reports**

EHR measure reports detail a provider's current percentages for meaningful use objectives, for a specific reporting period. Use the numerator, denominator, and percent values in the report when attesting for meaningful use (MU). See EHR Attestation.

The objectives that show are based on the provider's stage of MU (Modified Stage 2, Stage 1, or Stage 2). See EHR Set Meaningful Use Stage (440).

**Hints:**

- Check measure reports often to gauge progress and verify that percentages exceed each measure's requirement. Sometimes small steps determine the difference between meeting or not meeting a measure. Identifying and addressing data entry errors or missing information in the beginning days will make your job easier.
- When you have questions, this window is a useful tool to quickly review measure details. Drill down for each measure and see exactly which patients and actions are included in denominators and numerators.

**Running a report**

1. On the EHR Dashboard (400), click Measure Calc.

2. Enter the reporting period's start and end date.

3. Click the Provider dropdown and select the provider to report on.

Note: All providers who have the same last and first name will be grouped together in the same report. If using dummy providers, use the provider abbreviation to differentiate between providers since first and last name must be identical for EHR purposes.
1. Objective: The objective as described in specification sheets provided by CMS.
2. Measure: The measure as described in the specification sheets.
3. Audit: A list of all patients or actions included in the denominator for the measure. A brief explanation of what was, or was not entered, may also show.
   - Green entries indicate instances that count in the numerator. An X also shows in the Met column.
   - White entries indicate instances when data could have been entered, but wasn't.
4. Numerator: The number of audit items that were counted in the numerator.
5. Denominator: The number of eligible instances.
6. Percent: The numerator divided by the denominator, or the percentage.
7. Exclusion: If the measure offers an exclusion, an explanation will show. If the exclusion is based on a specific data value, Open Dental will track the data. For example, for CPOE medication orders, an exclusion is possible if you write less than 100 prescriptions. For this measure, Open Dental tracks and shows how many total prescriptions have been entered during the reporting period.
EHR: Reconciling from an Imported Summary of Care

When you receive a summary of care file (ccd.xml file) from another provider, you can electronically reconcile a patient's medications, allergies, or problems. Open Dental will automatically compare the Medications, Allergies, and/or Problems with the items listed in the summary of care file and make recommendations.

To reconcile medications using a paper document instead see EHR Reconcile from Paper Document.

Reconciling medications

1. On the EHR Dashboard, click Electronic Reconciliation.

2. Highlight the provider from whom the document came, then click OK to select. To add a new referral click Add. The referral must be marked as Is Doctor.

3. Summary of Care files that have already been received list as line items under Received.
   - To import a new Summary of Care, click File Import then select the file.
   - To open a received file, double click on it.
   - The document will open in a browser window.
4. At the bottom of the window, click **Medications**.

- By default, if medications are identified as a match (based on RxNorms(735)), the medication as listed in the patient's Open Dental medication list is used.
- To remove a medication from the Reconciled Medications list, highlight it then click **Remove Selected**.
- To add a medication from the Current Medications or Summary list, highlight it, then click Add. Any duplicate medications must be removed first.
The last modified date will always be today's date.

- Any notes attached to the medication will also be reconciled, so be aware of any notes in the patient's current Open Dental medication list. Compare the patient's current medications with those imported from the Summary of Care. Open Dental will automatically make recommendations and list them under Reconciled Medications.

5. When you are satisfied that the medications under Reconciled Medications are accurate, click OK to finish the reconcile and update the patient's Open Dental Medication List. Any medications that were reconciled, but didn't already exist in the Medication Master List (RxNorm), will be added to the master list.

**Allergy and problem reconciliation**
Allergies and problems can be reconciled electronically using the same steps as for medication reconciliation.

- **Allergies**: In the browser window, click Allergies. Allergies in a patient’s Allergy List will be automatically compared with allergies in the Summary of Care. Recommendations will list in the Reconciled Allergies list.

- **Problems**: In the browser window, click Problems. Problems in a patient’s Problem List will be automatically compared with problems in the Summary of Care. Recommendations will list in the Reconciled Problems list.

**EHR Reconcile from Paper Document**
If you receive a paper document of a patient's medications, allergies, or problems from another provider, you can manually reconcile them with the patient's medication, allergy, and problem list in Open Dental. For another reconcile option, see EHR: Reconciling from an Imported Summary of Care (436).

1. Scan the document and save it as an image file (e.g. JPG, PNG, GIF) in an Images folder.

2. On the EHR Dashboard (400), click Manual Reconciliation.

3. Highlight the provider from whom the document came, then click OK to select. To add new Referrals (76) click Add. The referral must be marked as Is Doctor. All referrals marked as Doctor will also show a Specialty.

The medications in the patient’s medication list show in the upper right.
4. Click [...] next to Image to Reconcile to view a list of all image files.

5. Highlight the image you scanned in step 1 and click OK. The image will display in the left half of the window.
6. Compare the medications in the image with the Medications list.
   - To add a medication to the patient's list, click Add Medication at the top of the window, then select the medication from the Medications List(1246).
   - To edit or remove a medication, double click the item under medications to open the Medication for Patient window.
7. When Medications are accurate, click Add to document that medications have been reconciled. A dated log entry will show under Reconciles.
EHR Set Meaningful Use Stage
The meaningful use (MU) stage setting determines which measures list on the EHR Dashboard (400) and in EHR Measure Reports (434). Stage settings can be set globally or by provider.

Setting globally
The global setting affects all providers whose EHR Meaningful Use setting on the Edit Provider Window is 'Use Global'.

1. In the Main Menu (592), click Setup, Chart, EHR.
2. In the upper left corner, click Settings.
3. Under Global Settings, click the dropdown to select the stage. There are three options.
   - Stage 1
   - Stage 2
   - EHR Modified Stage 2 (recommended for all providers in 2017)
4. Click OK to save.

Setting by provider
Stage can also be set by provider. When the provider is the primary provider, the EHR dashboard and measure reports will reflect their EHR Meaningful Use stage setting.

1. In the main menu, click Lists, Providers (1252).
2. Double click the provider.
3. For EHR Meaningful Use, click the dropdown to select the provider's stage.
   - Use Global: Use the global setting on the EHR Settings (711) window. This is the default.
   - Stage 1
   - Stage 2
   - Modified Stage 2 (recommended for all providers in 2017).
4. Click OK to save.

EHR CQMs Not Performed
When you document EHR Interventions (429) for an eligible patient encounter, it counts towards EHR Clinical Quality Measures (418). If an intervention or action is not performed, you can document the reason. Interventions and reasons not performed are usually documented while entering patient EHR Vital Signs (474) or Smoking Status (455).
To view all *not performed reasons* for a patient, or manually add reasons.

1. On the **EHR Dashboard** (400), click **Not Performed**.

   ![EHR Dashboard Screenshot](image)

   All reasons already entered are listed. Double click an entry to edit.

2. Click **Add** to enter a reason.

   ![Add Button](image)

3. Click the dropdown to select the item not performed, then click **OK**.

4. If **BMI Exam** or **Document CurrentMeds** is selected, the Not Performed Item with Reason window will show. If **Influenza Vaccination** or **Tobacco Screening** is selected, another input window will request the item not being performed.
5. Enter the reason, then click OK.

- Code: Click to select from a list of acceptable reasons. The code system name and code description will populate based on your selection.
- Note: Enter any notes.

**EHR Generate Patient List**

Patient lists for can be generated for a single condition or many. The intended purpose is for quality improvement, reduction of disparities, and research or outreach. This is not a reporting requirement for EHR Modified Stage 2.

1. On the EHR Dashboard (400), click **Generate List** (Patient List row, Click to Take Action column).
When you first open the window, there will be no data elements. As you select criteria, a line item will show for each.

2. Click a button on the right to add criteria. Some criteria have start/stop date options.

**Birthdate**: Include patients greater than, less than, or equal to a certain age.

**Problem**: Include patients with a certain [Problem](#468), [ICD-10 Codes](#129), or [SNOMED CT Codes](#727).

**Medication**: Include patients with a certain [Medication](#470).

**LabResult**: Include patients with lab results for specific [LOINC Codes](#728) that are greater than, less than, or equal to a specific value.

**Gender**: Include gender information in the list.

**Comm Pref**: Include patients with a specific communication preference as set on the Reminders window. See [EHR Document Reminders Sent to Patients](#444).

Allergy: Include patients with a certain [Allergy](#472).

3. Click Results to generate the list based on the criteria defined. To sort the list by a specific criteria, click on a column header.
4. To print the list, click Print.

List criteria will not be saved when you close the Patient List window. Each time you generate a list, you must define the criteria you want.

For EHR supporting documentation we recommend saving screenshots of the criteria and generated list.

**EHR Document Reminders Sent to Patients**

In EHR Modified Stage 2, there is no reporting requirement for reminders.

Reminders are notices sent to patients to remind them of preventive or follow-up care. Reminders are counted in the numerator for the EHR Reminders measure in two ways:

1. When you mark a reminder as *Sent* on the Reminders window (see below).
2. In version 15.1.21 and greater: When you send a recall reminder via the Recall List that has a Commlog type of Recall.

To determine which patients meet the stage 1 criteria for a reminder, generate a Patient List based on Birthdate. See EHR Generate Patient List. To also determine which patients meet criteria and had a completed procedure within a date range, use query #868 in Query Examples, specifying a birthdate, provider, and date range.

**Mark a reminder as sent on the reminders window**

1. On the EHR Dashboard, click Send reminders.
The Reminders grid lists any reminders that have been triggered for the patient, based on Reminder Rules. Reminder rules are optional and set patient criteria for a reminder (e.g. age, conditions). See EHR Reminder Rules(721). In the example above, the patient meets the criteria for being 5 years of age or younger.

2. Select the patient's preferred communication preference. Click Edit, select a confidential contact option, then click OK. This preference can be a filter in Patient Lists.

3. Select the reminder, then click Send to document that a reminder has been sent. A dated log entry will show in the Reminders Sent grid, and the numerator will increase in Measure Reports. See EHR Measure Reports(434).

EHR Summaries of Care

Summaries of care, also known as transition of care summaries, are EHR Continuity of Care Document (CCD)(414) that are sent to another provider when a patient is referred or transitioned. These documents are part of the EHR Health Information Exchange objective in EHR Modified Stage 2.

This page contains the following information:
- Providing a Summary of Care (measure 1)
- Sending a Summary of Care Electronically (measure 2)
- Previewing / Printing a Summary of Care
- Receiving a Summary of Care
- Troubleshooting

Providing a summary of care

Creating a Referral(76) automatically provides a summary of care to the patient portal (measure 1).
1. On the **EHR Dashboard** (400), click **Enter Referrals**, then **Referral To**.

![Select Referral](image)

2. Highlight the provider from whom the document came, then click OK to select. To add a new referral click Add. The referral must be marked **Is Doctor**. Do not select **None** as the referral.

![Edit Referral Attachment](image)

3. At a minimum, select the **Referring Provider** and make sure **Transition of Care** is checked. Click OK to close the Edit Referral Attachment window.

Referring provider default logic in version 14.3: For referring provider, by default the logged in provider is selected. If a provider is not logged in, the provider from most recent appointment is the default. If there is no provider on the most recent appointment, the patient's primary provider is the default.
4. The referral should be highlighted. Click Close to select.

The program will attempt to automatically send a summary of care to the patient portal. If successful, a dated entry will be added to the Sent grid, an X will indicate it counted towards Summary of Care (measure 1). If you are notified that information is missing, fill in the information then try again.

**Sending a summary of care electronically**

There are two ways to send a summary of care electronically (measure 2). Both require that you first have a method of securely sending summaries of care. You have two options:

1. Send directly from Open Dental using **Encrypted Email** (1662). This requires obtaining, installing, and sharing email security certificates.
2. Contract with a Health Information Service Provider (HISP) to perform authentication, encryption, and trust verification on your behalf. You can then export summaries of care and use the HISP to send securely.

**Email directly from Open Dental**

1. On the **EHR Dashboard** (400), click **Send/Receive summary of care**.

   ![Summary of Care window](image)

   2. Click **by Email**.
   3. Confirm and highlight the refer to provider (who the summary of care will be sent to), then click OK.
   4. The Edit Email Message window will open with the summary of care files attached. Enter the email message, and any other details. See **Email Message Edit** (1656).
   5. Click **Direct Message** to send the email securely.

**Export then send using a secure web service (HISP)**

1. On the EHR Dashboard, click **Send/Receive summary of care**.
2. On the Summary of Care window, click **Export**.
3. Confirm and highlight the refer to provider (who the summary of care will be sent to), then click OK.
4. Select where to export the summary of care CCD files on your computer, then click OK to export it.
5. Use a secure web service (e.g., a HISP) to send the files.

**Previewing/printing a summary of care**
1. On the EHR Dashboard, click *Send/Receive summary of care*.
2. On the Summary of Care window, click *Show xhtml*.
3. Confirm and highlight the refer to provider (who the summary of care will be sent to), then click OK. The Summary of Care file will open in human-readable format.

4. Click Print to print the file. Click *Show xml* to view the xml version of the file. Click Close to close the window.

**Receiving a summary of care**
The Received grid lists summaries of care (by date) that have been received from another provider. These files can be used for another EHR measure: Medication Reconciliation.

- File Import: Import a summary of care (ccd.xml) file from a location on your computer. The file will open, and a log entry will appear in the Received grid.
- Email: Open the Email Inbox to receive a summary of care that has been emailed to you.

Note: Summaries of care sent without encryption (e.g., not Direct Messaging) can also be imported, though sending without encryption may compromise patient privacy. You cannot block unencrypted emails from being received, but can contact the sender.

**Troubleshooting**

**Problem:** For the summary of care measure, you have entered a referral and provided a summary of care, but it is not counting in the measure calculation.

**Solution:** The summaries of care may not be attached to a referral. This can happen when a referral is entered separately from *providing the summary of care*, or if you click *none* for the referral when providing the summary of care. To attach the referrals to the summaries of care, update to version 14.3, then run Database Maintenance (1434).

**Problem:** Every time you generate a referral / summary of care, a WebMail is automatically sent to the patient.

**Solution:** This is the default setting to notify the patient. If you would like to turn off automatic summary of care WebMails, see EHR Settings (711).

**EHR Export Syndromic Surveillance Data**
See EHR Dashboard (400).

Syndromic Surveillance Data can be exported as an HL7 ADT standardized message. To record observations see Enter Syndromic Surveillance Observations (449).
Open Dental does not currently support automatic submission of syndromic data to state public health agencies. Rather, you must manually export observations by appointment, then submit to the public health agency using the required transport method. Since most dentists don't collect syndromic data, we think attesting to an exclusion is a good option. However, some states may not accept an exclusion.

Before exporting
The public health agency will require sign up and additional steps before data can be accepted. Contact your state’s public health agency to determine requirements, sign legal agreements, or begin the on-boarding process.

Exporting data
1. On the patient’s Edit Appointment(20), click Obs.

![Appointment Observations](image)

All observations already recorded and attached to the appointment are listed.

2. Click Export HL7.
3. Select the location in which to save the exported txt file, then click Save.

EHR Syndromic Surveillance Observations
See EHR Dashboard(400).

Syndromic surveillance data can be recorded during a patient's appointment, then exported as an HL7 ADT standardized message. See EHR Export Syndromic Surveillance Data(448).
1. Select the patient.
2. In the Appointments Module(1) or Chart Module(298), double click the appointment to open the Edit Appointment(20).
3. On the left side of the window, scroll down to the last of the appointment information fields.

4. Click **Obs**.

All observations already recorded and attached to the appointment are listed.

5. Click **Add** to add an observation.
6. Select the information, then click OK to save.
   - Observation Question: The data elements collected are based on EHR certification requirements.
     - BodyTemp
     - DateIllnessOrInjury
     - PatientAge
     - PrelimDiag
     - TriageNote
     - OxygenSaturation
     - ChiefComplaint
     - TreatFacilityID
     - TreatFacilityLocation
     - VisitType
   - Value Type: 5 values can be assigned to an observation question.
     - Address: Inserts the Practice address as the Facility Address.
     - Coded: Select a LOINC, SNOMEDCT, ICD9 or ICD10 code.
     - DateAndTime: Type the date/time in the Value field.
     - Numeric: Type the numeric value then select the Value Type.
     - Text: Type text in the Value field.

7. To export the data, see EHR Export Syndromic Surveillance Data(448).

EHR Vaccine Data

On the EHR Dashboard(400), click Vaccines.
If you administer vaccines, immunization data can be recorded in Open Dental, then exported in HL7 format (see EHR Export Vaccine Data(454)).

Note: Before entering vaccines, see EHR Vaccine Setup(718).

Listed are all vaccines already administered to the patient.

Click Add to add a new vaccine or double click to edit.
Enter the vaccine data, then click OK to save. Some information is required.

- **Vaccine Defs**: Options are defined in EHR Vaccine Setup (718). Drug Manufacturer will auto-populate based on the selected vaccine.

- **DateTime Start/Stop**: Auto-populated with today's date. When exporting vaccine data, the stop date may be blank, or may be the same as the start date. If any other values are entered for the stop date and an export is attempted, the export will be blocked.

- **Amount**: The numerical value of the dose administered. May be a fraction.

- **Units**: The amount's unit of measurement. Options are defined in EHR Vaccine Drug Units (720).

- **Lot Number and Date Expiration**: Required when exporting and Administration Note is NewRecord. Optional for historical vaccines.

- **City and State Where Filled**: Auto-populated based on the Practice (931) city and state. State is required when exporting. City is required when Completion Status is anything other than NotAdministered.

- **Completion Status and Refusal Reason**: Refusal Reason is required when exporting if Completion Status is Refused. If a Refusal Reason is specified when Completion Status is not Refused, then the export will be blocked.

- **Observations**: To add an observation, click Add.
Select the information, then click OK to save.

- **Observation Question**: The data elements collected are based on EHR certification requirements.
- **Value Type**: The value type to use for the observation Value. The selection will determine which data entry fields are enabled.
  - Coded: If selected, enables the Value Code System field (CVX, HL7064, SCT).
  - Dated: Type the date/time in the Value field.
  - Numeric: Type the numeric value then select the Value Units.
  - Text: Type text in the Value field.
  - DateAndTime: Enter the date as a Value.
- **Value Code System**: Only enabled if Coded is the Value Type. Select the code system.
- **Value Units**: Only enabled if Numeric is the Value Type. Select the unit of measurement.
- **Date Observed**: Enter a date or click Today to insert today’s date.
- **Method Code**: Only enabled if the observation question is FundPgmEligCat.

Vaccine data entry is less strict than vaccine exporting, so you may enter vaccine data without exporting if desired (e.g. non-EHR offices). See [EHR Export Vaccine Data](#).

## EHR Export Vaccine Data

If you administer and record vaccines, data can exported in HL7 format. See [EHR Vaccine Data](#).

Open Dental does not currently support automatic submission of vaccine data to immunization registries. Rather, you must manually export data, then submit to the registry using the required transport method. Since most dentists don’t administer vaccines, attesting to an exclusion is a good option. However, we recommend checking with your state for final recommendations.

### Before exporting

The immunization registry may require sign up and additional steps before data can be accepted. Contact your state to determine requirements, sign legal agreements, or begin the on-boarding process.

### Export data
1. On the EHR Dashboard(400), click Vaccines.

![Vaccines Interface]

Listed are all vaccines administered to the patient.

2. Indicate whether the patient does or does not want the vaccine data exported for use by other dental or medical offices. This is a per patient setting.
   - ??: unknown.
   - Yes: Patient has sanctioned vaccine information sharing.
   - No: Patient wants to keep the vaccine data within the dental office only. This setting never blocks the vaccine data export.

3. Select the vaccine data to export, then click Export HL7. You can select multiple vaccines to export at once.

4. Select the location in which to save the exported txt file, then click Save.

Note: The Submit HL7 button currently cannot be used because email is not secure.

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**EHR Tobacco**

In the EHR Dashboard(400), click Edit smoking status.
Alternatively, double-click in the Patient Info Medical area of the Chart Module (298), then click the Tobacco Use tab. Or double-click the Tobacco Use row in the Chart Module, Patient Info Medical area. To add this row to the Patient Info area, in Display Fields (900), add Tobacco Use to ChartPatientInformation.

Note: In any case EHR must be enabled.

Smoking status, tobacco use, and documented interventions affect EHR Clinical Quality Measures (418) in EHR Modified Stage 2.

A history of the patient's smoking status, tobacco use, and interventions show on the right.

**Current smoking status**
This status affects the percentage calculation for EHR Smoking Status. Click the dropdown to select the patient's current smoking status. The available options are based on SNOMED CT codes (see Importing Code Systems (726) to obtain all required code systems for EHR). If none is the selection, the status will not be counted in the numerator. Only one status selection per day will be added to the Assessment History.

**Tobacco Use Screening and Cessation Intervention (CQM)**
Document information for CQM #138 (Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention). This CQM calculates how many patients 18 years and older are assessed as 'tobacco user' and also receive a cessation counseling intervention. See EHR Clinical Quality Measure Descriptions (421).

Tobacco Use Assessment: Assess the patient's tobacco use. The date defaults to today's date.
1. Select the Assessment Type option that best describes the question asked to the patient. There are three options:
   - History of tobacco use Narrative.
   - Have you used tobacco in the last 30 days SAMH.
   - Have you used smokeless tobacco product in the last 30 days SAMH.
2. (optional) Select a Filter Statuses By option to filter the Tobacco Status list.
   - All = all statuses
   - User = status options for tobacco users
   - Non-User = status options for non-tobacco users
   - Frequent = status options used most often
3. Click the Tobacco Status dropdown to select the patient's current tobacco status. The available options are based on SNOMED CT codes. To select a different code, select Choose from all SNOMED CT codes. If you use a code that is not recommended CQMs percentages may be affected.
4. Click Add Assessment. A log entry for today's date will be added to the Assessment History. Multiple entries can be added for the same day.
To edit an assessment date, enter notes, document tobacco use start date, or rate desire to quit, double click an Assessment History log entry.

The following items can be changed:

- **Date Time**
- **More information about the event**: Any relevant notes.
- **Tobacco Use Start Date**: The date when the patient started using tobacco (MM/DD/YY). Open Dental will automatically calculate the duration. Informational only.
- **Tobacco Use Desire to Quit**: Rate the patient's desire to quit using tobacco on a scale of 1 - 10. Informational only.

Cessation Intervention: If patient is assessed as a tobacco user, document an Intervention(429). The date defaults to today's date.

1. (optional) Select a Filter Codes by option to filter the Intervention Code list.
   - All = all interventions
   - User = interventions for tobacco users
   - Non-User = interventions for non-tobacco users
   - Frequent = interventions used most often
2. Click the Intervention Code dropdown to select the intervention.
3. **Patient Declined**: Check to indicate a patient is declining the intervention (optional). This is informational only. Declined interventions still count in CQMs.
4. Click **Add Intervention** to add a log entry to Intervention History. If you select a medication, the Medication for Patient window will open so you can enter instructions and start date. The medication will be added to the Medications(470) list.

To edit an intervention's date or patient declined status, enter notes, or delete an intervention, double click the intervention under Intervention History. The documented intervention will be highlighted in the list.

**Family Health History**

In the Chart Module(298), double-click the pink medical area and select the Family History tab.
Alternatively, in the EHR Dashboard (400) click Enter family history, and click the Family Health History tab. Here you may document the health history of a patient's family member on the Medical (466), Family Health History tab. This tab is only visible if EHR is turned on in Show Features (806).

Click Add Family History, or double click an entry to edit.

Enter the relationship details:

- **Relationship**: Select the family member's relationship to the patient.
- **Name**: Enter the family member's name.
- **Problem**: Click Pick to select a problem from the Problem List (1250). It must be a problem with a SNOMED CT code (727).

Click OK to save.

You may select a no problems known problem from the Problem List, however it must be associated with a SNOMED CT code. Code #160245001 has a description of No current problems or disability (situation).

**EHR Radiology Order List**

For EHR providers, radiology orders must be entered using CPOE, meaning they must be entered or approved by a provider. Starting in version 15.4, all procedures marked as Is Radiology are automatically flagged as radiology orders. By default, all x-ray procedures (D0210 - D0340 and D0364 - D0386) are marked Is Radiology in the Procedure Codes (1195).
To count as CPOE, the EHR provider must add it themselves or approve the radiology procedure before it is marked complete.

- Note: For measure calculation details, see EHR Objective 3: Computerized Provider Order Entry (CPOE).
- In version 15.3 and earlier, radiology orders had to be manually entered by a provider using the lab order interface and a RAD code. You can still use this process to enter orders. See EHR Lab Order RAD codes.

CPOE vs non-CPOE orders
Radiology orders are automatically marked as CPOE when the EHR provider is logged on and does the following:

- Adds the procedure with a treatment planned status via chart, appointment, or treatment plan.
- Opens the treatment planned procedure for any reason (double click the procedure in the Chart module).
- Approves radiology procedures using the Radiology List (see below).
- Sets the procedure (or appointment) complete.

A radiology order is not marked CPOE when another user is logged on (non-EHR provider) and does the following:

- Adds the procedure with a treatment planned status via chart, appointment or treatment plan.
- Sets a non-approved procedure complete.

Approving orders using the Radiology List
If the logged-on provider has radiology orders with a treatment planned (TP) status that are not already marked CPOE, an alert shows in the Open Dental menu bar. These alerts only show for providers with EHR Annual Provider Keys who are subscribed to Radiology Order alerts. See Alerts to subscribe the provider to the alert.

These orders can be quickly approved by the provider using the Radiology List.

1. Make sure the EHR provider is logged on to Open Dental.
2. Open the Radiology List. There are three ways to open it:
   - Click Radiology Orders alert, Open Radiology Orders.
   - Click the Appointment Lists icon, then Radiology.
   - On the EHR Dashboard, click Approve radiology orders.
All of the provider’s upcoming radiology procedures that are attached to scheduled appointments, have a status of treatment planned (TP) and are not yet marked CPOE will list. The goal is for this list to be empty, meaning all of the logged-on provider’s radiology procedures are already approved. If a non-EHR provider is logged-on, the list will always be empty.

- To sort orders by date, name, code, abbr, or description, click a column header.
- To quickly go to a patient’s Chart or Family module, right click on the patient, then click See Chart or See Family.
- This window is non-modal; you can keep it open while opening other windows. (Exception: it is not non-modal when accessed via the EHR dashboard).

3. To approve all orders, click All. To approve selected orders only, highlight the orders, then click Selected.

4. Once approved, the orders will no longer show in the list. Click Close to close the window.

**Logic**

Notes: To show in the radiology list, procedures must meet this criteria:

- Flagged as *is Radiology* (Procedure Code List).
- Have a status of TP.
- Is not yet approved.
- Associated to the logged in provider.
- Attached to an appointment with a status of scheduled and is in the future.

If a procedure is marked as *is hygiene* and the appointment is scheduled in the hygiene operatory, the procedure will show in the Hygienist’s radiology list.

**Chart Layout**

Use Chart Layout to create custom views of the Chart Module.

In the [Chart Module](298), click Layout.
Alternatively, click Setup, Sheets.

See our QuickTip: Dynamic Chart Layout video for a brief overview.

Double-click on a custom sheet with the type ChartModule, or click New to edit.

Layouts are edited in the same manner as sheets. See Edit Sheet Def(1125) and Sheet Special Field(1149) for information on editing sheets.

Note: Fields cannot overlap or be placed below the PatientInfo field.
Treatment Plan in Chart

In the Chart Module, at the middle right, check the Treatment Plans box.

This will display Treatment Plans and Procedures grid instead of Progress Notes. This view also allows you to create new treatment plans from the Chart.

To turn this option on, check the Treatment Plans box on the Enter Treatment tab. This checkbox only shows when Is TP View is also selected for the Chart View on the Show tab.

Active and inactive treatment plans list in the Treatment Plans list. Saved treatment plans do not. When you select a treatment plan, its procedures will show on the graphical tooth chart and list under Procedures. If you select all treatment plans, all treatment planned procedures all procedures will show in the graphical tooth chart and list under Procedures.

If no treatment has been entered for a patient, the Treatment Plans list may be blank. As soon as you chart any treatment, an Active Treatment Plan is created that contains the treatment planned procedures.

Create a New Treatment Plan

1. Click New TP.
2. **Heading:** Enter the name of the new treatment plan.

3. **Note:** Change the note if desired. Set the default note in Treatment Module Preferences.

4. Use the left/right arrows to copy procedures that are already part of a treatment plan to or from the Treatment Planned Procedures list.
   - **Treatment Planned Procedures:** The procedures in this treatment plan.
   - **Available Procedures:** Procedures added to other active or inactive treatment plans.

5. To make this plan active, click **Make Active Treatment Plan**.

6. Click OK to save.

The Status column indicates the procedure's status. Once a procedure is complete, it no longer lists as an available or treatment planned procedure.
- TP: Procedure is part of an active treatment plan.
- TPI: Procedure is part of an inactive treatment plan.

The Apt column indicates the appointment status of the procedure. A procedure can have more than one status.
- blank: Procedure is not planned, scheduled, or part of a broken appointment.
- P: Procedure is part of a planned appointment.
- S: Procedure is scheduled. These procedures cannot be removed from an active treatment plan.
- U: Procedure is part of an appointment on the Unscheduled List. These procedures cannot be removed from an active treatment plan.
- B: Procedure is part of a broken appointment. These procedures cannot be removed from an active treatment plan.

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**Add Procedures to a Treatment Plan**
You can add procedures to a single treatment plan or to multiple treatment plans at once.
1. Highlight the treatment plan(s).
2. Chart treatment as normal (select teeth, add procedures). As procedures are added, the graphical tooth chart will reflect the changes.

If no treatment is selected prior to charting treatment (e.g. when not in TP view), procedures will be added to the active treatment plan. If no active plan already exists, a new one will be created.

**Change Priorities in a Treatment Plan**

1. Highlight the treatment plan(s).
2. Highlight the procedure(s).
3. Under Set Priority, click the priority level. Options are set in Definitions: Treat' Plan Priorities(893).

**Change the Status of a Treatment Plan / Make it Active**

One treatment plan will always have an active status. However the active treatment plan can be replaced.
1. Double click the treatment plan to make active.
2. Click Make Active Treatment Plan.
3. Click OK.

**Graphical Tooth Chart**

In the Chart Module(298), at the upper left, is the graphical tooth chart.

This chart visually shows the patient's teeth, as well as treatment that has been performed, is planned, or has been referred out.

To select a tooth, click on it. Click a tooth again to deselect. Click and drag to quickly select multiple teeth. Drag the slider bar under the chart to show procedure changes to the tooth chart over time.

**Tooth Numbering:** The default numbering system is set in Chart Module Preferences(706), Tooth Nomenclature.

**Tooth Graphics:**
A procedure code's paint type and treatment area determines the graphic used in the tooth chart. Some treatment areas show no graphic (e.g. mouth). See Procedure Code (1200).

- Colors are dependent on:
  - Procedure status (treatment planned, complete, existing other provider, existing current provider, referred, condition).
  - The colors set in Definitions: Chart Graphic Colors (855).

- To quickly see the current colors for each status, click the Draw tab (Draw on Tooth Chart (332)). If you change colors, we recommend also changing the text color for Definitions: Prog Note Colors (884) to match. By convention, procedures that use metal are a dark color, while those that use ceramic, porcelain, or plastic are a light color. In rare situations, a procedure code may have a color override, in which case color will not indicate status.
- The procedure statuses that show depend on the settings for this chart view.
- Supernumerary teeth do not show on the chart, and thus procedures for supernumerary teeth also do not show. You can, however, draw them freehand using the Draw tab.

**Show Big:** To view a full screen version of the chart, click the Tooth Chart drop down in the toolbar, then Show Big. See Big Graphical Tooth Chart (466).

**Save the Tooth Chart:** To save a snapshot of the chart, click the Tooth Chart drop down in the toolbar, then Save to Images. The image will be saved in the Images module under Tooth Charts, named with the save date. Snapshots are especially important for pediatric offices to see history of tooth eruption.

Other Related Links:
- Primary / Permanent Teeth (324)
- Missing Teeth (323)
- Tooth Movements (323)
- Show Chart Views (328)
- Enter Treatment (301)

**Troubleshooting**

If you chart a procedure and it is not showing accurately on the tooth chart:

1. Verify that the treatment area for the procedure code is accurate. Certain Paint Types require a specific Treatment Area.
2. Make sure Hide Graphics is not checked on the Procedure (303), as this causes the procedure not to show on the chart.
3. Verify that the procedure's status is viewed in this Chart View.
4. If your tooth chart looks different, it could be due to graphic preferences. These options can be selected by clicking File, Graphics (see Graphics Preferences (603)). For example, the Simple Tooth Chart looks like this:
Big Graphical Tooth Chart
In the Chart Module toolbar, click Tooth Chart dropdown, Show Big.

Viewing a full screen version of the Graphical Tooth Chart can be useful when explaining treatment to patients.

Medical
In the Chart Module, at the lower left, is the pink Medical area.
Double-click on a row in the pink area to enter information on the Medical window. The default tab that opens depends on the row clicked.

Note: The rows that show in medical area can be customized in Display Fields(900), ChartPatientInformation. To change the background color, see Definitions: Misc Colors(876).

**Medical Info:** Enter general medical information.

- **Print Medical:** Print a list of the patient's problems, allergies, medical history, premedicate status (Y/N), medically urgent notes, and medical summary.
- **Premedicate:** If checked and PremedFlag is added to an appointment view, Premedicate will show in the Chart module medical area (bold red) and in the appointment box. It will also show when you hover over an appointment if Med Flag is added to the appointment bubble in Display Fields.
• **Current Meds Documented**: EHR only. See [EHR Attest Medications Documented](420).

• **Med Urgent**: Entered text will show in bold red in the Chart module medical area, in the appointment box if Med Note is added to the appointment view, and when you hover over an appointment if Med Flag is added to the appointment bubble in Display Fields.

• **Medical Summary**: Entered text will show in the Chart module medical area.

• **Medical History**: This section should always reflect the current medical status. The assistants should type in all items that the patient marks on a medical history form. Once the data is entered into the computer, the dentist can refer to it more easily than the handwritten patient version. There is no archiving or update mechanism, so all changes should also be entered as chart notes.

• **Service Notes**: Enter useful information that is learned through discussions with patients, such as hobbies, employment, whether they need a blanket or pillow, nervous behavior, whether they are on a strict budget, whether they have to drive a long way to get to the office, etc. Shows in the Chart module medical area.

**Problems**: Maintain a list of a patient's active and inactive problems. See [Problems](468).

**Medications**: Maintain a list of the patient's current and discontinued medications. See [Medications](470).

**Allergies**: Maintain a list of the patient's current and inactive allergies. See [Allergies](472).

**Family Health History**: Document the health history of a patient's family members. This tab is only visible if EHR is turned on. See [Family Health History](457).

**Vital Signs**: Document a patient's pulse, height, weight, and/or blood pressure, and any interventions. See [EHR Vital Signs](474).

**Tobacco Use**: Assess patient smoking status, tobacco use, and document interventions. This tab is only visible if EHR is turned on. See [EHR Tobacco](455).

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**Problems**

In the [Chart Module](298), double-click the pink [Medical area](466). Click the **Problems** tab.
Add Problem: Add a problem from the Problem List.(1250).

Show Inactive Problems: List problems with an inactive status.

Problems: A list of entered problems. Double click a problem to change start/stop dates, status, or notes. The EHR InfoButton(428) may show if EHR is turned on.

Active problems also show in the Chart module medical area in bold red. Every time you add, edit, or remove a patient problem, an entry is made in the Audit Trail(1424).

Add a problem
1. Click Add Problem to open the Problem List. The patient’s current active problems will highlight.
2. Double click on the problem to add it to the patient’s list of problems.

Edit a problem
You can change a problem’s status or enter start/stop dates or notes. To change SNOMED CT codes or ICD codes, see Problem List instead.

1. Double click the problem.
2. Enter the problem details.
3. Click OK to save.

**Status:** There are three options: Active, Resolved, Inactive. Resolved usually means an acute problem that will never return (e.g., fractured hip or an infection). Inactive usually means a problem that may return (e.g., diabetes or angina).

**Start/Stop Date:** Enter the dates, or click Today to insert the current date (optional).

**Note:** Enter any patient-specific notes (optional).

EHR only: The settings below determine if this problem shows on a Summary of Care.

**Problem Type:** Must be set to Problem for this condition to show.

**Functional Status:** If Problem, this will show under Problems. If CognitiveResult, CognitiveProblem, FunctionalResult, or FunctionalProblem, this will show under Functional Status.

**Medications**

In the Chart Module(298), double-click the pink Medical(466) area. Click the Medications tab.
Add Medication: Add a medication from the Medications List (1246).

Show Discontinued Medications: List medications that have a Stop Date prior to today's date.

Print Medications: Print a list of the patient's medications.

Medication: A list of this patient's entered medications. Double-click a medication to change start/stop dates, provider, count, instructions, and refills. The EHR Info Button (428) may show if EHR is turned on.

Notes: Medication specific notes.

Notes for Patient: Medication notes specific to the patient.

Status: Displays whether the status of a medication is active or inactive based on the Stop Date.

Source: If the medication came from an eRX integration, it will display as DoseSpot or Legacy. A blank source indicates the medication was created in Open Dental.

Active medications also list in the Chart module medical area. Every time you add, edit or remove a patient medication, an entry is made in the Audit Trail.

Add a Medication
Click Add Medication to open the Medications List, All Medications tab.

Double-click a medication to select it. If you do not see the medication, you can add it to the master list.
The Medication area lists the drug information as entered in the Medications List.

**Provider**: Click the drop down to change the provider.

**Notes for this Patient**: Enter patient-specific notes. If EHR is turned on, this area will be labeled Count, Instructions, Refills.

**Date Start**: Enter the date the medication was started, if known. Click Today to insert today's date.

**Date Stop**: Enter the date the medication was stopped, if known. Click Today to insert today's date. As long as the Date Stop is a future date or left blank, the medication will be considered active. If the stop date is prior to today's date, the medication is considered inactive/discontinued. If using eRx Companies (349), when a medication is marked discontinued in eRx, a stop date will automatically be entered for the medication in Open Dental when the Chart module is refreshed.

**Remove**: Remove this medication from the patient's medication list.

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**Allergies**

Allergy information can be entered for each patient.

In the **Medical** (466) window, click the **Allergies** tab.
Add Allergy: Add an allergy from the Allergy List (1221).

Show Inactive Allergies: List allergies that have been marked inactive.

Allergies: A list of entered allergies. Double click an allergy to edit. The EHR Info Button (428) may show if EHR is turned on.

Active allergies show in the Chart module medical area in bold red. Every time you add, edit or remove a patient allergy, an entry is made in the Audit Trail (1424).

Add or Edit Allergies
Click Add Allergy, or double click an existing allergy to edit.

- **Allergy**: Select the allergy. All available options are those set up in the Allergy List.
- **SNOMED CT Reaction (EHR only)**: Click [...] to select SNOMED CT Codes (727) (sent in the XML of a EHR Continuity of Care Document (CCD) (414)/summary of care). Click None to clear the box.
- **Reaction Description**: Enter the allergic reaction (optional).
- **Date Adverse Reaction**: Enter the date of the reaction (optional).
- **Is Active**: By default the box is checked. To mark an allergy inactive, uncheck the box.

Click OK to save.
EHR Vital Signs
Document a patient's vital signs on the Medical tab. Vital signs can include height, weight, blood pressure, and pulse.

1. In the Chart Module, double-click the pink medical area, or on the EHR Dashboard, click any vital signs row.
2. Click the Vital Signs tab.

**Add Vital Sign:** Add vital sign entries.

**Growth Chart:** For patients who are 0 - 20 years of age, view a plotted chart of vital sign changes. See EHR Growth Chart.

**Vital Signs:** A list of vital sign entries, sorted by date. Double-click to edit.

**Documentation for Followup or Ineligible** will show no text; this is leftover from 2011 certification.

3. Click Add Vital Sign, or double-click an entry to edit. The patient's age will determine which information shows in the window.
4. Enter the vital sign information.
   - **Date**: The date of the entry.
   - **Systolic/Diastolic BP**: Blood pressure measurements. Corresponding LOINC Codes (728) will show.
   - **Height**: Patient's height in inches. Height Code is automatically selected when height is entered; you can select another option if desired. Required when sending prescriptions through Legacy eRx (349).
   - **Weight**: Patient's weight in pounds (lbs). Weight Code is automatically selected when weight is entered; you can select another option if desired. Required when sending prescriptions through Legacy eRx (349).
   - **BMI**: Automatically calculated using height and weight. If BMI is flagged as underweight or overweight, and the patient is older than 18, an Intervention area will show at the bottom of the window. A corresponding LOINC code will show.
   - **BMI Percentile**: Only visible for patients 3 to 16 years of age as of January 1. A corresponding LOINC code will show.
   - **Pulse**: The patient's pulse in beats per minute.

5. If applicable, enter CQM exclusion reasons or interventions.

**Exclusion from BMI Exam**: This information is included in Clinical Quality Measure (418) exclusions. If BMI height and weight are not recorded due to a patient's condition, select the checkbox that explains the reason.

- **Pregnancy**: Check this box if patient is/was pregnant during measurement period. If you have set a default pregnancy code in EHR Settings (711), it will show as the Pregnancy Code and Description. If you have not set a default, the Problem List (1250) will open so you can select one. To set a default, click Change Default. Once selected, a diagnosis of pregnancy, using this code, will also be added to the patient's list of problems with a start date equal to exam date,
if an active diagnosis doesn’t already exist. Pregnant patients will not count in the denominator of associated CQMs, though will show as an exclusion.

- **Other Reason**: Check this box if height/weight is not recorded for a reason other than pregnancy, then document the [Reason not Performed](440). If a valid reason is documented, this patient will not be calculated in the denominator of associated CQMs.

**Interventions and/or Medications**: This area only shows in the following circumstances:

If a patient is 16 years of age or younger as of January 1 of the exam year, and a height and weight is entered.

If a patient is 18 or older, height and weight are entered, and the calculated BMI is flagged as underweight or overweight.

1. Click to document an [Intervention](429).

2. Enter the date. The default is today’s date.

3. Click on an intervention. To filter the list by intervention type, click the **Code Set** dropdown.

   - Patients 16 or younger: Nutritional Counseling and Physical Activity Counseling interventions are listed.
   - Patients 18 or older: Above/Below Normal Weight referral, medication, or follow up interventions are listed.

4. If patient declines the intervention, click [Patient Declined](430).

5. Enter a note (optional).

6. Click OK. If you select a medication, the Medication for Patient window will open so you can enter instructions and start date. See [Medications](470).

7. Click OK to save the vital sign entry.
EHR Growth Chart

In the Medical area, Vital Signs tab, click Growth Chart.

The growth chart is a plotted chart of a patient's Vital Sign changes for patients 0 - 20 years of age. The current growth chart is not very useful. You cannot print it and there is no comparison with average population values.

In order to show plotted points, a birth date must be entered on the Edit Patient Information.
Procedure Sort Order

Below is a description of how procedures are sorted in various areas of Open Dental.

In the Chart Module (298), with the default Chart View, items are sorted in this order:
1. Date (oldest on top)
2. Type (task, procedure, sheet, etc.)

Procedures are sorted in this order:
1. Date (oldest on top)
2. Status (treatment planned procedures show before completed procedures)
3. Priority (highest to lowest based on the order on priority options)
4. Tooth number (no tooth number first, then lowest to highest)
5. Procedure Code (CDT code lowest to highest)

Treatment Plan Module (283)

Treatment Plans will always sort by Priority first (highest to lowest based on the order of priority options). Then procedures will be sorted within the priorities using the following:

If Sort by - Tooth is selected:
Tooth Number (no tooth number first, then lowest to highest)

If Sort by - Order Entered is selected:
Date (oldest on top, based on the Date field in Procedure Info window), then order entered.

Note: It does not sort by procedure code. If two codes have the same priority, tooth number, and date then the order is random. It may be in the order charted but it may not. The order could even change.

Account Module (150)
1. Date (oldest on top)
2. Tooth number (no tooth number first, then lowest to highest)
3. Procedure Code (CDT code lowest to highest)

Claim (208)
• Priority (highest to lowest based on the order of priority options). This is very difficult to identify since priority does not show on the claim.
• Tooth number (no tooth number first, then lowest to highest)
• Date (oldest on top)
• None. It does not sort by procedure code. If two codes have the same priority, tooth number, and date then the order is random. It may be in the order charted but it may not. The order could even change.

It may be helpful to create a custom chart view that shows the columns in the order they are sorted. Priority is very handy to add to the chart view when there are sorting questions.

Open Dental does not sort procedures charted on the same day chronologically by time (e.g. procedures earlier in the day do not necessarily show before procedures completed later in the day). This may be challenging for practices that desire this (e.g. practices that do dentures).
**Finalize Insurance Payment** (231) - procedures attached to the payment. On the Insurance Payment (EOB) window the default order of procedures attached to the payment is random; there is no order. Manually reorder items using the up/down arrows.

**Procedure Group Note**
In the Chart Module (298), press Ctrl and highlight multiple procedures. Right click and select **Group Note**.

A group **Note** (320) is a single clinical note made for multiple procedures in the Chart Module (298). All procedures must be set complete, have the same date, and have the same provider. Group notes show in the Progress Notes after the last associated procedure.
The group note is stored in the database as a procedure.

- Set default group notes by editing the Procedure Code (1195) as GRP.
- Security permission to edit or delete group notes is based on the status of attached procedures. If attached to at least one completed procedure, it is controlled by Edit Completed Procedure permission. Otherwise it is controlled by TP Procedure Delete. See Permissions (1118).
- Users must have the GroupNoteEditSigned permission to delete a group note.
- Group note text color in the progress notes can be customized in Definitions: Prog Note Colors (884), Status Existing Current Prov.

**User:** The user tied to the electronic signature. By default it will be the logged-on user. To override, click [...] and enter log on credentials.

**Auto Note:** Select and complete Auto Notes (317).

**Notes:** Enter the group note. If attached procedures have default procedure notes, they will be combined into one group note and appear in the Notes text box. This behavior can be changed in Chart Module Preferences (706), Procedure Group Note Does Aggregate.

**Signature/Initials:** Electronically sign the note. The signature will be tied to the user listed above the notes area. If a note is edited later, the signature will be cleared. See Electronic Signatures (306).

**Procedures:** The procedures attached to this group note. The columns that display can be customized in Display Fields (900).

**Aggregate Group Notes**
Aggregate Group notes allow you to create a group note that pulls in procedure notes started on individual procedures. The preference is enabled from Chart Module Preferences (706) by checking the box for Procedure Group Notes aggregate.

See our QuickTip: Using Aggregate Procedure Notes video for a brief overview.

**Invalidated Group Notes**
These are created if you have turned on Procedure Lock (1416), which is not recommended. Invalidated group notes cannot be deleted.

**Images Module**
The Images Module (1) is a place to scan and store most forms and letters that you would normally store in a paper chart.
When you scan forms or images, they are saved as simple jpg files, making them always available to other programs. In addition to scanning forms, you can also import other file types, including Word, PDF, and Excel formats.

Note: For more complex digital imaging requirements (e.g. x-rays), you need imaging software. It is very common to use one program for dental practice management and a different program for image management. See Program Bridges for information on using the many bridges that we support.

Files are organized in tree view by categories (folders). The documents within a folder/category are based on files stored in the patient's A to Z Folder.

See Images Module Preferences to determine whether the tree view is collapsed or expanded.

See Definitions: Image Categories to customize folders/categories.

- An earth behind the folder icon indicates the folder is shared to Patient Portal. See Definitions, Image Categories, Show in Patient Portal.

- Right-click on an image file to print, delete, or get more information.
- Single click on an image file (jpg, gif) or PDF, to preview it in the window on the right. For other file types, there is no preview capability.
- Double-click an item to open it in its default program. For example, a Word file (doc) would open in MS Word. Jpg and gif files will not open in a default program if double-clicked since they are already previewed.

Images are sorted chronologically by the date and time created (hour/minute/seconds). To change the sort order, edit the date and/or time in the info window (see Image Information below).

**Images Toolbar**

![Images Toolbar](image-url)
**Printer**: Opens the Select Printer window so you can print the selected image. The image will automatically be sized to fit the printed page.

**X**: Delete the selected image.

**I**: Display image information, such category, name, date, type and description. Some information can be changed. See Image Information below.

**Sign**: Open the Signature window to attach a note to the selected image and electronically sign it. See Electronic Signatures (306).

**Scan Document**: Use the flatbed scanner of your attached device to Scan a single page document.

**Scan Multi-Page Document**: Use the automatic document feeder (ADF) of your attached device to scan multiple pages.

**Scan Radiograph**: Select when you are scanning a radiograph. The pixel windowing settings set in Imaging Setup will be used as the default. Also see Enhancing Radiograph Images (742).

**Scan Photo**: Scan a photo. Will automatically select Photos image category.

**Import**: Import an existing file from your computer or network. You can only import one file at a time.

**Export**: Export a file to another location on your computer or network.

**Copy**: Copy the selected image to the clipboard. Does not work with PDFs.

**Paste**: Paste an item from the clipboard into the selected image folder.

**Template**: See Template Forms (486).

**Capture**: Capture an image with a Suni Sensor (1066).

The options below only work with image files, not PDFs.

**Slider**: Click and drag each edge of the slider left or right to adjust the pixel windowing values for the selected image. Windowing is useful for images like radiographs because it isolates gray levels. Changes are visible in the preview as you drag. For more details, see Enhancing Radiograph Images.

**Crop tool**: Click to activate, then click and drag to draw a rectangle around the part of the image you want to keep. When you release the mouse button, a confirmation message will show. Click OK to remove the parts of the image outside of the drawn rectangle. This cannot be undone.

**Hand tool mode**: Click to activate, then click on the image and drag to move it around the preview pane.

**Magnifying Glass**: Zoom in and out in 50% increments. Click 100 to view at 100%.

**Rotate**: The last three buttons let you flip and rotate the image in 90 and 180 degree increments. Flipping only changes the way an image is displayed, it does not change the actual file. The reason being that the image is in a compressed format, and changing it would result in a slight loss of data as the image is recompressed.

**Image Information**

To access and edit file information, click the Info button in the toolbar or right-click on a file, then click Info. This window will also open when you scan or import a file.
**Categories**: Correspond to folder names. Select the category the image should be stored under. Customize options in Definitions, Image Categories.

**File Name**: The name and location of the file. Files are automatically named using this format: LastnameFirstnameUniquenumer (the autoindex number of the document table in the database). They are stored in the patient's A to Z folder.

**Date and Time**: Defaults to the time the image was captured. Affects sort order.

**Type**: Determines the type of document you have entered. Changing the type will change the file icon in the list.

**Tooth Numbers**: If this file pertains to a tooth, you can enter numbers for reference.

**Optional Description**: This will show in tree view with the file date.

**Audit Trail**: View a log of all changes to the item (creating, editing, deleting).

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**Moving Files into the Images Module**

To move files into the Images Module, you have four options.

1. Scan the documents or images. See Scanning(484).
2. Import files from another location on your computer.
3. Drag and drop files from a Windows folder directly into an Images folder. This will not work if Open Dental is running as an administrator.
4. Copy/Paste an image from the clipboard. Within another program, copy the image to the clipboard (Ctrl + C or Edit, Copy). Or copy an active window to the clipboard by pressing Alt + PrtScn (Print Screen is usually at the top of the keyboard above the arrow keys). Then, in the Images module, select the category and click Paste. Pasted images will not be compressed, but generally only take up 1/4 of the space of a scanned document. See also Print Screen Tool(1400) to capture screen shots that you do not want to save with any particular patient.

If you copy/paste an existing image that's already in OpenDental, the file size may get bloated, especially if it starts out as a gif. All such images get converted to jpg with zero compression, resulting in some bloat. The current recommendation for duplicating a gif is to copy it directly to the A to Z folders using Windows. Then, return to the OpenDental Images module and refresh. The new file will be picked up and attached to the patient.
5. Copy directly into the patient’s folder. In Windows, simply select and copy the files, then paste the files into the patient’s folder in the A to Z folders. The next time you open the Images module for the patient, the files will be automatically added to the tree view, and you can re-categorize or rename. This is useful when copying large quantities of files at once. Once recognized by Open Dental, DO NOT rename or move the files, or Open Dental will not know where to find them.

Troubleshooting
Error: HRESULT E_FAIL has been returned from a call to a COM component.
Solution: This error can occur when you select a PDF image in the Images module and your internet browser does not have the proper plugin. To resolve follow these steps:
1. Set Internet Explorer as the default internet browser.
3. Open the PDF file using Internet Explorer. The PDF should open in Internet Explorer, not Adobe.
4. In Open Dental, Images module, open the PDF file. It should now be viewable.

If desired, you may change back to your original default internet browser.

Scanning
At the top of the Images Module(480) are four buttons for scanning forms, letters, documents, photos, and radiographs into a patient's record.

Scan Document: Use the flatbed scanner of your attached device to scan a single page document. File will be saved as a JPG.

Scan Multi-Page Document: Use the automatic document feeder (ADF) of your attached device to scan multiple pages. Adobe Reader must be installed. File will be saved as a PDF.

Scan Radiograph: Select when you are scanning a radiograph. The pixel windowing settings set in Image Setup will be used as the default.

Scan Photo: Scan a photo.

General Scanning Instructions
1. Click Scan Document or Scan Multi-Page Document. The Select Source window will show.

2. Select your scanner, then click Select. The Scanner Options window will show.
3. Choose **Custom Settings**, then **Adjust the quality of the scanned picture** to optimize document size and quality.

4. Select the settings, then click **OK**.
   Typical Settings:
   - Documents: 150 dpi.
   - Panos: grayscale, 300 dpi.
   - BWs: grayscale, 400 dpi.
   - Photos: color, 300 dpi.

5. Click **Scan**, then wait ~10 seconds.
6. The image will show in the Images module, and the Item Info window will show. Enter a description and select the category this document should be stored under. Then click OK.

**Template Forms**

Templates are frequently used images or PDF files that can be quickly saved to a patient.

In the **Images Module** (480), click Template.
Select an image from the Template dropdown menu then choose which image category from the Item Info window to save a copy of the image too. Once saved, add notes, electronically sign, or print the image. If signed, the note cannot be changed without invalidating the signature. See Electronic Signatures(306).

For documents that require a patient to fill out, see Patient Forms(1690)/Registration Forms(1695) and Consent Form(395). Letters(1678) are also an alternative to templates.

**Add Templates**
To add an image to the dropdown list, navigate to Forms in the A to Z Folders(826). If a folder called Forms does not exist, add it.

Copy/paste any image into this folder to act as a template.

Restart Open Dental. New templates will be available in the dropdown list.

**Manage Module**
The Manage Module(1) contains miscellaneous management functions that don't apply to any single patient.
Daily Area

Send Claims: Send, print, and manage insurance claims. See Send Claims(489).

Batch Ins: Enter batch insurance payments. See Batch Insurance Payment(501).

Billing: Print or email batch statements and set billing defaults. See Billing(504).

Deposits: Create Deposit Slip(516).

Supply Inventory: Track suppliers, supplies, orders, and equipment. See Supply Inventory(519).

TSI Collections: See TSI Collections(527).

Tasks: Set up task lists and create tasks for office communication, reminders, appointment lists, patient lists, etc. See Tasks Area(536).

Backup: Use Open Dental's manual Backup Tool(539).

Accounting: Set up a chart of accounts and track expenses, income, assets, liabilities and equity. See Accounting(546).

Email Inbox: Launch the Email Inbox(561).

ERAs: Process ERAs(568).

Import Ins Plans: Only visible when Public Health(71) is turned on. This is a very specific function for importing 834 files. Import Ins Plan 834(579).

Time Clock
Employees can use the Time Clock(582) to clock in/out of work.
- Manage: Manage employee time cards, calculate daily/weekly totals, and run reports. See Manage Time Cards(583).
• **View Time Card**: Employees can view or edit their time card. See [TimeCard](587).
• **View Breaks**: Employees can view or edit their breaks. See Editing Time Cards.
• **View Schedule**: Quickly view the schedule for selected employees. See [Schedule View Employee](590).

**Server Time**: The server time is used to time stamp all events in your database (commlogs, audit trail, tasks, etc). This time is pulled from the server hosting your Open Dental database. If the time is changed on your server, a restart to the mySQL service may be required.

**Messaging**
Send internal text, light and sound messages to all workstations in the office. See [Messaging](581).

**Send Claims**
In the [Manage Module](487), click Send Claims.

![Insurance Claims window](image)

Insurance claims can be sent, printed, and managed on the Insurance Claims window.
• Print or send claims as part of a batch..
• View a history of sent claims, printed claims, and reports.
• View and process ERAs(568) received from a clearinghouse.
• Create batch claims for unbilled procedures. See [Procedures Not Billed to Insurance - New Claims](493).

This window is non-modal so you can open other windows while sending or validating e-claim.

**Claims Waiting to Send**
The top half of the window lists claims that have a status of *Waiting to Send*. Click a column header to sort.
• **DateService**: Date of service on the claims. Dates showing 01/01/0001 indicate a preauthorization.
• **Patient Name**: The patient that is attached to the claim.
• **Carrier Name**: The insurance plan attached to the patient.
• **Clinic**: If using clinics, the clinic the claim is associated with.
• **Provider**: The treating provider on the claim.
• **M/D**: Indicates whether the claim is Medical (Med) or Dental (Dent).
• **Clearinghouse**: Determined by the insurance plan's setting for *Don't usually send electronically* ([Insurance Plan](81)). If checked, paper will list. If unchecked, the default clearinghouse will list.
• **Warnings**: Indicates when a user attempts to send a deleted or already sent claim.
• **Missing Info**: Indicates the claims validation status. If *validated when sending*, the claim has not been validated for missing information yet. If missing information is listed, it must be completed before resending. Right click on the claim to Go To Account. If the column is blank, the claim has been successfully validated with no missing information found.
• ProcCodes: Procedures attached to the claim.

Filter options:
• **Clinic Filter**: Only visible when Clinics is turned on. Filter claims by clinic to easily send each clinic’s claims to a specific clearinghouse. The logged-on user must have access to a clinic to view or send claims for that clinic.

• **Next Unsent**: Automatically select the next clinic with unsent claims.

• **Custom Tracking Filter**: List claims by recorded claim tracking status. Custom tracking data is entered on the **Edit Claim - Status History Tab** (219).

**Preview**: View the selected claim before sending or printing. You can also double-click a claim in the grid to preview.

**Blank**: Print a blank version of the default claim form.

**Print**:
• To print all claims marked as *Paper*, click Print (don’t select any claims). All claims marked as *Paper* will auto-select and a confirmation message will show. Click OK to proceed.

• To print specific claims, select them, then click Print. Select multiple claims by clicking and dragging, pressing Ctrl while clicking, or pressing Shift while clicking.

  - **Note**: Paper vs clearinghouse is determined by the setting *Don’t usually send electronically* on the **Edit Insurance Plan** (124) window.
  - Printing a claim automatically changes its status to sent.

**Labels**: Print individual labels for selected insurance carriers.

**Send E-Claims**: All claims will be validated before sending to ensure no information is missing.
• To send all claims as a single batch to the clearinghouse listed in the Clearinghouse column, click Send E-Claims or click the dropdown to select the clearinghouse. A confirmation message will show. Click **Yes** to proceed.

  - **Note**: Claims with *Paper* as the clearinghouse will be ignored.
  - If sending secondary claims using ClaimConnect and NEA Fast Attach, any attachments must be uploaded to NEA first. See **Electronic Attachments** (227).
  - For e-claim troubleshooting, see **E-Claims Complexities** (496).

**Validate Claims**: Validate selected e-claims for missing information prior to sending.
• Open Dental always validates e-claims when sending. If a claim has missing information, no claims in the batch will send and Missing Info will list in the last column. If a claim has already been sent, a warning will show and the claim will not be resent.

• To validate claims when the Insurance Claims window loads (before sending), check the **Claim Send window validate on load** in **Manage Module Preferences** (744). This may be useful for smaller offices.

**Get Reports**: Manually retrieve reports from a clearinghouse. See Reports below.

**Refresh**: Update the Claims Waiting to Send grid.

**Procs Not Billed**: Open the **Procedures Not Billed to Insurance Report** (1318) and optionally create batch claims for unbilled procedures.

**Close**: Close the window.

**Claim History**
The lower History grid lists all claims sent or printed from this window and received reports (e.g. ERAs, acknowledgment reports). Double click an item to view more information. Right click an item to Go To Account. The list of claims and reports can be filtered by date or type.

**Date From / To**: Only show claims and reports in a date range.
• Manually enter the dates.
Click the down arrow to select dates from a calendar then click the up arrow to collapse the calendar.
Click the W buttons to jump back or forward one week.

**Type:** Only show certain types of claims or reports. Single click an option, or to select multiple types, press Ctrl while clicking or Shift while clicking. If no options are selected, then all types will show.

- ClaimSent
- ClaimPrinted
- Claim_Ren: Renaissance claims.
- StatusNotify_277: A health care claim 277 acknowledgment that notifies of claim status. See Acknowledgment Reports below.
- TextReport: Any report that is not a 997, 999, 277, or ERA_835. See Text Reports below.
- ERA_835: An electronic EOB, also known as electronic remittance advice or ERA. The AckCode indicates the ERA status. If blank, some or all claims on the ERA are not received. If Received, all claims have been received, but payment must be finalized. Double click an ERA to process it.
- Ack Interchange

**Undo:** If there was a problem with sending, highlight the claims and click Undo. The claims will move back to the Claims Waiting to Send grid.

**Print List:** Print the current contents of the History grid.

**Outstanding Claims:** Open the Outstanding Insurance Claims Report(1315).

**Claim History Grid**
- Patient Name: The patient that is attached to the claim.
- Carrier Name: The insurance plan attached to the patient.
- Clearinghouse: The clearinghouse that the claim was sent to, where applicable.
- Type: Displays the type of claim or report. See Type, above.
- AckCode: The status on a Claim Ack 277(495). This column will show A or R (accepted/rejected).
- Note: Double click the item to enter a note in this column.
- User: The logged-on user that sent the claim, where applicable.

Note: In order for a report to list, it must already exist in the clearinghouse's default Report Path. You can set up automatic download, manually download (click Get Reports), or manually save the report file in the correct folder. Not all insurance carriers offer ERAs, reports, or the ability to automatically download.

**Claim Details**
To view details about a sent claim, double click it.
If there is ever any need to troubleshoot a sent claim, the full text of the batch is saved here. Most of the text, as well as the fields below, are meaningful only to technical support.

**Attachments Sent**: Indicates if attachments were sent.

**Note**: Add a note that will display on the Insurance Claims window.

**Acknowledgment**: If the transaction has been acknowledged by the clearinghouse, then that information, including the full Message Text and Date/Time, will show at the right.

**Reports**
In order for a report to list in the History grid, it must first be downloaded to the Clearinghouse Report Path.
- To set up automatic download, see Clearinghouses(645). Only certain clearinghouses allow automatic download.
- To manually download, click Get Reports or manually save the report file to the correct report path.

Note: If you are using Change Healthcare, update to version 16.2.62 and install .NET 4.5 by November 1, 2016 to retain claim report functionality.

Reports can only be retrieved once per minute. If a user attempts to retrieve reports more than once in a minute, they will get an error. As reports are retrieved a progress bar will appear. Errors will be recorded in the Error Log. Users can pause or cancel the progress at any time.
Acknowledgment Reports: There are 4 types of acknowledgment report formats; 997, 999, 277, and 835. They are listed in the order in which they are received from the clearinghouse. Clearinghouses are not obligated to provide these acknowledgment reports and may choose to return some or all reports for some batches and not others.

- **997 & 999**: Open Dental has supported format 997 (functional acknowledgment) for years. Support for format 999 (implementation acknowledgment) was added in Version 12.3. The 997 and 999 are simpler formats that only provide information regarding the status of a batch based purely on formatting and data requirements. When a 997 or 999 is received by Open Dental, the AckCode column in the History grid for the corresponding claims are set to A for accepted or R for rejected. To view the acknowledgment message text, double click on the sent claim.

- **277**: Shows in the History grid with a Type of StatusNotify_277. This report provides more detailed status information about the sent batch than a 997 or 999 format. Support for the 277 format was added in Version 12.3.

- **835**: Also known as the electronic remittance advice or ERA. The 835 report shows in the History grid with a Type of ERA_835.

Text Reports: Reports usually come back from the clearinghouse as files placed in the report path specified in the Edit Clearinghouse window. They are then automatically imported by Open Dental and stored in the database. The original text file is deleted. Older versions of Open Dental did not store the report in the database, but instead moved the file to an archive folder. Because of the new way that reports are handled, it is no longer important to always run e-claims from the same workstation. However, if you use Tesia, then TesiaLink should only be running on one computer at a time. Also, there is no need to manually archive reports. Reports that have been imported will show as rows in the lower history grid. Double click on the row to view or print. Use the Note field to make comments about each report that you will find useful.

Some clearinghouses use a web-based follow-up system rather than sending back text reports.

**Questions & Answers**

When sending medical e-claims, why do I receive a message Cannot send claim until missing data is fixed: proc e-claim note missing?

All CPT codes that end in 99 require that an e-claim note is entered on the Procedure(303).

**Procedures Not Billed to Insurance - New Claims**

In Send Claims(489), click Procs Not Billed.
Alternatively, in Standard Reports, click Procedures Not Billed to Insurance.

Use the Procedures Not Billed to Insurance Report to automatically create multiple claims for insured patients who have unbilled procedures.

All insured patients with unbilled procedures that meet the filter criteria will list.

Change the filter criteria as needed, then click Refresh. From/To: Defaults to today's date. To change, click a down arrow, then select the report start date in the first calendar and the end date in the second calendar. To close the calendars, click an up arrow again or Refresh.

Clinics: Highlight the Clinics to include. Click All to select all clinics or press Ctrl while clicking to select multiple. Click Refresh to update the list. Only visible when Clinics is turned on.

Include Medical Procedures: By default the report will only include procedures for patients who have dental insurance plans. To also include procedures for patients who have medical insurance, check this box.

Automatically Group Procedures: When checked and procedures for a patient have different clinics or place of service, claims for each clinic/place of service will be created. When unchecked, you will be blocked from creating claims when patient procedures have different clinic/place of service.

Highlight the procedures to create a claim for, then click New Claims. A message will indicate the number of claims that may be created.

Note: Creating batch claims from this window requires the NewClaimsProcNotBilled Security Permission. See User Group for details on enabling required permissions.
Click OK to proceed. Another message will indicate the number of claims created.

Click OK to close.

- Note: To send or print the new claims, see Send Claims (489).
- For Canada, a maximum of seven procedures can exist per claim. If there are more procedures, multiple claims will be created.

Claim Ack 277

In Send Claims (489), under History, double-click a StatusNotify_277 row.
The 277 format for E-Claims(645) acknowledgment reports contains more detailed status information about the sent batch than a 997 or 999 format. Support for the 227 format was added in version 12.3. Also see Send Claims(489).

When a 277 is received:
- In the Insurance Claims History grid, the corresponding rows for the sent claims have an AckCode column set to A or R.
- The 277 also shows as a separate row with a Type of StatusNotify_277. Double-click the row to open the Claim Status Response window.

The only information from the above window that gets automatically processed/imported is the claim status column (Accepted or Rejected).

E-Claims Complexities
This page includes technical information about what goes out on E-Claims(645). For troubleshooting, see E-Claims Errors(500).

Also see Claim Addresses(223).
**Updating to 5010 Format**

Electronic claims are sent and received using the standard EDI X12 837 data format.
- This format meets HIPAA requirements for the electronic submission of healthcare claim information.
- Within the standard are two versions, 4010 and 5010. Version 5010 is preferred because it is newer and has more fields available.
- Each e-claim consists of loops, segments, and elements.

To use the 5010 format:
1. Edit your Clearinghouses (645) to use the 5010 format.
2. Update your Practice (931) address to include the full 9 digit zip code within your Open Dental database.
3. Monitor your reports for dropped claims or other problems.

**Optional Patient ID**

5010 e-claims: The Optional Patient ID is not sent because the Member ID field was removed between versions 4010 and 5010. A check to block users from sending claims if the Optional Patient ID exists was added in version 12.2.3. The message that shows up when a claim is blocked due to the existence of this field is as follows: "Create a new insurance plan instead of using the optional patient ID."

4010 e-claims: This field was sent in element NM109 of loop 2010CA when the patient is not the subscriber. This field is known in the standard documentation as the Member ID. When the Optional Patient ID is blank, the patient SSN (with dashes removed) is sent in the Member ID field if the SSN is not blank.

**Prosthesis (Initial or Replacement)**

E-claims: There is no claim-level field for this information. The information is instead attached directly to each procedure. The claim-level field that is shown in the Claim (208) will be completely ignored on e-claims. All e-claims are validated before they are sent. If the procedure-level prosthesis information is missing in the Procedure (303) for any prosthesis procedure, the e-claim cannot be sent.

Paper claims: The opposite is true: procedure-level prosthesis information is ignored and all that goes out on the claim is the claim-level information.

**Claim Note**

*Edit Claim window, Claim Note:* On both e-claims and printed claims, the Attachment ID Number (Edit Claim - Attachments Tab (214)) is included at the beginning of the note. For example, if the Attachment ID Number is NEA#4521687 and the Claim Note is *Patient is anemic*, then the combined note would be *NEA#4521687 Patient is anemic*.

The Claim Note box is limited to 255 characters. On printed claims, the entire combined note is printed. On e-claims, only the first 80 characters of the combined note are sent in the NTE segment of loop 2300. The 80 character limit is a restriction of the standard electronic format and is beyond our control.

*Procedure Info window, E-claim Note:* limited to 80 characters. This note is sent on e-claims in the NTE segment of loop 2400 in version 4010, and in the SV3 segment of loop 2400 in version 5010. Again, the 80 character limit is a restriction of the standard electronic format and is beyond our control. The procedure e-claim note is not included on printed claims.

**CLM01**

The specifications state, *The number that the submitter transmits in this position is echoed back to the submitter in the 835 transaction. The two recommended identifiers are either the Patient Account Number or the Claim Number in the billing submitter's patient management system. The developers of this implementation guide strongly recommend that submitters use completely unique numbers for this field for each individual claim.*

Prior to version 7.0, the internal OD ClaimNum was used because it is unique for each claim. But it turns out that the PatNum is much more useful because some clearinghouses display this number in their reports. And if the number is PatNum, then it becomes very easy for the office to look up the patient being referenced. We currently use PatNum/ClaimNum, for example 3246/5412.

Emdeon is known to add their own unique string to the end of whatever number is sent so that the number will be unique. In the case of a preauthorization followed by a claim, DentiCal requires that the number in this field be identical in both
submissions. The string added by Emdeon would seem to break the requirement by DentiCal. DentiCal “has no funds” to refine their interfaces, so there may not be a workable solution.

DentalXChange replaces (but stores) the claim ID received on the claim with a unique claim ID since very few PMS programs supply unique numbers. You are able to search claims by either ID in ClaimConnect so that you will have the unique claim ID available if checking on a claim with a Payer.

Regardless of which clearinghouse is used, Open Dental does not submit an identical string in the claims as was submitted in the preauthorization. This behavior is consistent with the X-12 specifications, but does not follow the DentiCal requirements. It is a feature request to be able to send an identical CLM01 in both a preauth and subsequent claim.

**Preauthorization DCN**
This is only an issue with DentiCal. For other carriers, please see the discussion further down regarding the Original Reference Number in 2300 REF (F8).

**Prior Authorization Number**
Also called the Preauthorization Number.

In the X12 documentation, this is called 2300 REF (G1): Prior Authorization. This number can be sent from the Claim Edit window within the Prior Authorization dropdown inside of the Misc tab. You can add this field, PriorAuthString, to your paper claim form by placing it to the right of the PreAuthString field. When carriers want a preauthorization number, they are probably referring to this field.

**Predetermination of Benefits Number**
In the X12 documentation, this is called 2300 REF (G3): Predetermination Identification. This number can be sent from the Claim Edit window within the Predeterm Benefits box. On the paper Claim Form, we show this field as PreAuthString.

**Quadrants**
From time to time, we get complaints about claim rejections due to missing quadrants. We have reviewed numerous paper and electronic claims in response to the various complaints, but have never found a problem. The quadrant is clearly listed every time. On paper claims, there is a column labeled 25. Area of Oral Cavity. In this column, there should be a number, either 10, 20, 30, or 40 that corresponds to the quadrants UR, UL, LL or LR. Due to rejections by insurance companies, we began tacking the letter version of the quadrant onto the beginning of the description in addition to sending the number in box 25.

For e-claims, to verify that the number is going out correctly, from the Insurance Claims window (Send Claims(489)), open the raw text of the sent claim. It will be easier to troubleshoot if there is only a single claim in the batch. Look about 2/3 of the way down the claim for the row(s) that start with SV3. For example, an SRP with code D4341, a fee of $175, performed in an office (11), with a quadrant of UL (20), and a quantity of 1, would look like this:

```
SV3*AD:D4341*175*11*20**1~
```

It’s easy to see by looking at the SV3 rows that the quadrants are being properly sent. We have never seen a situation where they were not being sent. But if you have an example of such a situation, we would be happy to review it. We continue to be baffled by the periodic claim rejections.

6/26/2012 It has been suggested that some insurance companies are requiring UL etc in box 27, the tooth number box. The same letters would presumably go out in the same place on e-claims. This sounds like it might be plausible, but we have seen no documentation stating that this is required by any insurance company. More importantly, it would also violate the HIPAA standard, which every insurance company is required by law to follow. If someone provides us proof that an insurance company is requiring this format, then we will add it as an option. But we strongly suspect that it would cause rejections from other insurance companies.

**Original Reference Number**
In the X12 documentation, this is called 2300 REF (F8): Original Reference Number. In other places, it seems to be called one of the following:
- Original Document Control Number/Internal Control Number (DCN/ICN)
- Original Transaction Control Number (TCN)
- Claim Reference Number
- Payer Claim Control Number (in new 5010 documentation)
This field is required by Medicaid when voiding a claim or replacing a claim by setting the CLM05-3. The ability to send void or replacement claims was added in version 12.2 within the Claim Edit window.

**Attachment Control Number (ACN)**

In the X12 documentation, this is placed in the Claim Supplemental Information loop, 2300 PWK06. To send an ACN in Open Dental, enter the number in the Attachment ID Number field in the Edit Claim window. There can be only one ACN per claim.

There is a checkbox in the Account Module Preferences, Insurance tab for Requires ACN# in remarks on claims w/ ADDP group name. This is an enforcement policy that was requested by one user. Their carrier expects the ACN# in the remarks of the claim.

Medicaid of Iowa providers may now submit electronic claims relative to an approved Exception to Policy (ETP). Providers are instructed to enter the Exception to Policy number in the Attachment Control Number (ACN) field 2300 PWK06. When completing the ACN field the ETP number must be preceded with the letters ETP. Ex. ETP08-E1234.

**Clinics and Providers**

Providers should not move between clinics prior to version 11.1. In the Insurance Claims window, we encouraged but did not enforce sending claims for only one clinic at a time. A batch of claims goes to the clearinghouse as a single hierarchical file, grouped by billing provider. The billing address for a group of providers is pulled from the first claim in the group under the assumption that the provider/clinic relationship won't change in that group. This has been resolved in version 11.1 by enforcing batches to all belong to a single clinic.

**Ordering Provider**

Ordering Provider is only used in medical e-claims on a procedure level. The ordering provider in loop 2420E (one per procedure) is required for DMERC (Medicaid) carriers only and must be a person, not an organization, according to the X12 standard.

By default, the ordering provider is the treating provider, but it can be changed.
- Version 16.3.22 and greater: Option to select a referring provider as the ordering provider override.
- Version 16.2.56 and greater, 16.3.14 and greater: Option to set the treating provider as the default ordering provider or to leave it blank (Account Module Preferences(693)). If the carrier is Medicaid (see Electronic Payer IDs(691)) the treating provider is always sent as the ordering provider, regardless of the preference.
- Version 14.2 and greater:
  1. Set an ordering provider override on the procedure (Procedure - Medical Tab(314)) or claim (Edit Claim - Medical Tab (219)). If an override is set on the procedure, it overrides providers set elsewhere.
  2. If no override is set, the preference in Account Module Preferences for On e-claims, send treating provider info for each separate procedure determines the default ordering provider.
    - Checked: The provider set on the procedure will be the ordering provider.
    - Unchecked: The treating dentist set on the Edit Claim window will be the procedure's ordering provider.

Note: If an overriding ordering provider on a procedure is not a person (Not a Person checked on Provider(1255)), or has no last name, no ordering provider information will be sent with the claim.

**Sites**

If a Site is assigned to a procedure on a claim, and a default provider (not a person) and place of service (not office) are set for the site, the site NPI, place of service, and address will be sent in loop 2310C for new 5010 dental e-claims. This is the criteria that must be met:
- At least one procedure on the claim must have a site assigned.
- The site must have a default provider that is marked as Not a Person and has a valid NPI.
- The site must have a valid address, city, state, and zip code.
- The claim place of service is not Office.
- The site provider and claim billing provider cannot match.

**Service Authorization Exception Code**

Open Dental does not currently send or support this code. It is described in the X12 documentation as follows:

Used only in claims where providers are required by state law (e.g., New York State Medicaid) to obtain authorization for specific services but, for the reasons listed in REF02, performed the services without obtaining the service authorization. Check with your state Medicaid to see if this applies in your state.
**Resubmission Codes**

Resubmission codes are determined by the Correction Type in the Misc Tab of the Edit Claim window.

Original=1, Replacement=7, Void=8.

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**Medical E-Claims**

If Medical Insurance (128) is involved, E-Claims are created differently. You will use Change Healthcare Medical E-Claims (667) to process your claims.

**Insurance Plan:** On the Insurance Plan (81), check the Medical Insurance box. This is used for medical and institutional claims, and controls whether claims go out in dental format or in medical/institutional format. Also set the Claim Form to UB04 or 1500, in case you print paper claims.

**Setup:** In Account Module Preferences (693) there is a checkbox for 'Set medical claims to institutional when using medical insurance'. This setting will affect all insurance plans set as 'medical' and determines whether claims are created as medical (837-P) or institutional (837-I). The user can change this option for individual claims (see below).

**Claim:** Create the medical claim in the Account Module (150), probably by selecting the procedure and clicking the New Claim dropdown in the toolbar, then Medical. The Med/Dent and Claim Form settings can be changed on the Edit Claim window.

**Clearinghouse:** In Clearinghouses (645), set a default for dental and a separate default for medical/institutional. Dental clearinghouses cannot accept medical or institutional claims. If you will generate claim files from Open Dental and upload them manually to Medicaid, you still need to set up a clearinghouse to specify the Claim Export Path. The format for dental claims can be 4010 or 5010, and you can freely switch between them as needed. Medical and institutional claim format will be only 5010.

**Send Claims:** When Sending Claims (489), send batches of claims to one clearinghouse at once. [Technical note: To determine the format, information is required from both the claim.MedType and the clearinghouse.Eformat. Neither alone is sufficient.] Once messages are generated, they are archived in the etrans table in the database for later retrieval. These archived claims may be seen in the history list at the bottom of the Insurance Claims window. All 4 claim types (med5010, inst5010, dent5010, dent4010) will show as “claim sent” in the archival.

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**E-Claims Errors**

When Sending E-Claims (489), some fields are optional within the e-claim format. Some carriers will require the field and others will not. This page details common error messages from a carrier due to data that is "required and missing" and how to enter the missing information. For more details, see E-Claims Complexities (496).

**The clearinghouse states that the claim was rejected because Loop 2000B segment SBR element 03 is missing.**

On the Insurance Plan (81) for the carrier, enter the Group Number for the carrier the claim was sent to and send the claim again.

**The clearinghouse states that the claim was rejected because Loop 2320 segment SBR element 03 is missing.**

On the Edit Insurance Plan window for the other carrier, enter the other plan’s Group Number and send the claim again. For example, if submitting to the primary plan, the other carrier is the secondary carrier. If submitting to the secondary plan, the other carrier is the primary carrier. For a tertiary plan, the other plan is the secondary plan. For a fourth plan, the other insurance would be the tertiary, etc.
Batch Insurance Payment

In the Manage Module(487), click Batch Ins.

This window is for entering a large batch of claims on a single EOB. For a smaller batch or single claim, see Finalize Insurance Payment(231).

Large batch insurance payment entry is useful when there are many claims on a single EOB or when multiple people enter payments at the same time. There are two different ways to enter large batch payments:

- In the Manage Module(487), Batch Ins, create the payment, then receive and attach claims.
- In the Account Module(150), receive the claims (see Receive Claim(229)). Then in the Manage Module click Batch Ins to create the payment and attach the claims.

Supplemental payment amounts can only be received in the Account module. See Supplemental Insurance Payments(237). Once received, it can be attached to a batch payment.

Create the Payment and Attach Claims

Payments already entered are listed. If a payment has only been partially entered, an X shows in the Partial column. Simply double click a payment to continue. If the EOB has been scanned, an X shows in the Scanned column.

To filter the list of payments, select criteria at the top, then click Refresh.

- **From/To Date:** Filter by payment date. The default range is the last 10 days.
- **Clinic:** If using Clinics, filter by payment clinic.
- **Payment Group:** Filter by claim payment group.

Click Add to create a new payment.
Enter the payment information.

- **Clinic**: Select the clinic.
- **Payment Type**: Customize options in Definitions: Insurance Payment Types (872).
- **Payment Group**: Typically used to group payments when multiple people are entering payments at once. Customize options in Definitions: Claim Payment Groups (860).
- **Payment Date**: Defaults to today’s date.
- **Issue Date**: Optional.
- **Amount**: The total amount of the payment.
- **Check# and Bank-Branch**: Optional, but useful for reporting.
- **Carrier Name**: Click Pick to select from the Carriers (1237), or type a name.
- **Note**: A general note.
- **Prepaid Credit Cards**: Click a button to process payments via a virtual credit card. Buttons are only visible if XCharge (OpenEdge) (173) or PayConnect Window (168) is enabled. When the transaction is complete, the Edit Insurance Payment window will still be open and transaction details will show in the Note.

Click OK to save details and proceed.
Payment Details: Information entered on the previous window. Click Edit to change.

All Outstanding Claims: All claims with a sent status for the insurance carrier.
- Claims are sorted first by carrier, then by patient.
- Claims that haven't been received will have a payment of 0. If there is a payment amount, the claim has been received but not attached to a payment.
- **Carrier:** Filter outstanding claim by a different carrier. Enter the name in the Carrier field. If you think you are missing a claim, search for a similar carrier (e.g. if BCBS, search for Blue Cross or similar), or click (...) to pick from a list.
- **Name:** Filter outstanding claims by patient name. Enter either the patient's first or last name in the Name field.
- **ClaimID:** Filter the outstanding claims by ClaimID. If known, enter the claimID.

If needed, attach claims that haven't been received:
1. Double click on the claim to open the Edit Claim window.
2. Receive the claim by procedure or by total amount.
3. Click OK on the Edit Claim window. The claim will automatically move to the Attached to this Payment grid and the Total Payment amount will auto-calculate.

If a claim is already received, simply highlight the claim, then click Attach.
- **Note:** Right click, then click Go To to quickly jump to the Account Module with that specific claim highlighted.
- To sort claims in the Attached to this Payment grid (e.g. in the order of the EOB), click the Up/Down arrows on the far left. By default claims are sorted in the order they were entered.
- Click Attach/Detach to add or remove claims from the Attached to this Payment grid.

Click View to scan EOBs. See Scan EOB(234).
When the correct claims are attached, and the payment Amount and Total Payments match, click Close.

If payment amounts don't match, then clicking Close marks the batch payment as partial. Simply double click a partial batch payment to continue. When payment amounts match, clicking Close locks the payment. To make changes, you must delete the batch payment and reenter.

Batch insurance payments can be accessed from the Batch Insurance window, or viewed by claim via the Account module (Edit Claim window).

**Questions & Answers**

What if I cannot enter (receive) all of the claims that make up my bulk check/payments and I need to leave for the day?

Do not finalize the payment until you finish receiving all the claims. This way all claim payments will have the same payment date.

We have multiple people entering payments. How can we make sure the payments balance?

Assign payment groups to each payment. This will group payments together. Then run the Daily Payments Report(1294) by payment group.

**Billing**

Batch billing can be run daily, monthly, or per your practice preference.

In the Manage Module(487), click **Billing**.
By default, patients only receive a bill if they have not been billed in the last 30 days. To generate a single statement, invoice, or receipt, see Statements (269) instead.

These options determine which statements show when generating the Billing List (507). We recommend you save default options so they are the same each time you generate the list. If using Clinics (1505), default filter options can also be saved for each clinic.

Note: If the Billing List opens instead, a list has already been created and there are unsent bills. Before you can generate a new list, you must send the unsent bills or delete them. To delete, click Close, then click Yes to the delete message. You will receive a notification when the deletion is successful. Click OK and the window will close. Click Billing to start again.

**Other Resources:**
- Billing Webinars

**Setup:** Set defaults and billing list filter options.
- Manage Module Preferences (744): Default statement and billing options.
**Billing Defaults** (510): Set the general message, date range defaults, and electronic billing credentials (if sending eStatements).

**Dunning Messages** (513)

**Electronic Billing** (514): Regular email is not a secure method of sending statements (PHI).

General Steps:
- Run **Billing/Finance Charges** (1428) (once a month).
- Run **Repeating Charges** (1465).
- Verify billing options.

**Filter Options**

Filter options show on the left of the window.

Note: To save default filter options by clinic, select the clinic first, select the options, then click Save As Default.

**Include anyone not billed since:** Include statements for families who have not been billed since this date. It defaults to one month prior and usually does not need to be changed.

**Include any accounts with insurance payments, procedures, or payplan charges since the last bill:** Include statements for families who may have received a bill in the last 30 days, but have since had an insurance payment come in, had procedures completed, or has payment plan charges due or charges that will be due within the number of days set in Manage Module Preferences (744), **Days in advance to bill payment plan amounts due**.

**Age of Account:** Only generate statements for families who have account balances in a specific Aging (1423) category (Any Balance, over 30 days, over 60 days, over 90 days).

**Exclude bad addresses (no zipcode):** Do not create statements for guarantors with no zip code.

**Exclude inactive families:** Do not create statements for families where all members have a status of inactive. The intent is to allow you to track outstanding balances for inactive families without sending a bill for the balance.

Note: If other family members are continuing to receive treatment and you check this box, no statement will be generated for them.

**Exclude if insurance pending:** Do not create statements for families who have one or more family members with an outstanding claim (any status other than received).

**Exclude if unsent dental procedures:** Do not create statements for families with one or more family members who have unsent dental procedures dated in the last 6 months. The purpose of this option is to prevent sending a statement before a claim is created (e.g. in larger organizations where billing is done in a separate department).

**Exclude if balance is less than:** Do not generate statements for families that have a balance less than a set amount. Negative numbers are allowed.

**Show negative balances (credits):** Create statements for families with a negative balance (they have paid more than they owe). If checked, these patients will be included even if you have entered a negative balance value for **Exclude if balance is less than**. If unchecked, patients with negative balances will not be forcefully excluded. Rather, the **Exclude if balance is less than value** will be considered.

Examples:
- To include all families, regardless of balance (positive, negative, 0 balances): Exclude if balance is less than = 0, check Show negative balances.
- To only include families with balances of 0 or more: Exclude if balance is less than = 0, uncheck Show negative balances.
- To only include families with a positive or negative balance, but not 0 balances: Exclude if balance is less than = .01, check Show negative balances.
- To exclude families with balances less than $1: Exclude if balance is less than = 1, uncheck Show negative balances.
Ignore Walkout (In Person) statements: If checked, families who were given a walkout statement will be included in the billing list.

Billing Types: Select the billing types to include. Click and drag, or press Ctrl while clicking to select multiple types. Customize options in Definitions: Billing Types(850).

Clinic: This clinic selection determines which clinic's default filter options show and. It can also be used to filter the billing list. Users can only select clinics they have access to. To set filter options for a specific clinic, select the clinic before selecting any filter options. Click the drop down to switch clinics or select All to select all clinics.

Use clinic default billing options: Only shows when All is the selected clinic. Useful when each clinic has different filter defaults, yet you want to run the billing list for all clinics at once. Checking this option will generate each clinic's statements using its filter defaults.

Save As Default: Save the selected settings as the default filter options. Also saves changes made to the General Message, Account History Date Range and Dunning Messages. If a clinic is selected, the options will be saved for the selected clinic.

Other Options
The default settings for the options below are determined by Billing Defaults(510).

- **Account History Date Range:** Set start and end date to determine how much account activity will show on each statement. Click Last 30 Days, Last 45 Days, and Last 90 Days to quickly set the desired date range. Clicking All Dates will clear the start date and will print the entire account history on each statement. Note: If using Electronic Billing(514), and you have selected All Dates, a warning will appear asking you to confirm. Using All Dates can result in statements that are many pages long.

- **Only show transactions since last zero balance:** If checked, all transactions since the last date the account balance was zero will print on the statement. The default Account History Date Range will be ignored.

- **Defaults:** Access Billing Defaults(510).

- **Intermingle Family Members:** When checked, family members will be mixed together on the statement and ordered by date. When unchecked, each family member will have their own section on the statement with a total. Electronic billing is always intermingled.

- **Group by Super Family:** Only an option if Super Family(143) is enabled. Check the box to create super statements instead of statements for each super family guarantor. A super statement will be addressed to the head of the super family and include account activity for all super family members, grouped by guarantor.

- **Send text messages for these modes:** Opt to send an additional text message about a statement when it is sent from the billing list. Only statements with modes that match selected modes will receive a text message, as long as the patient is eligible to receive text messages. The message can include a clickable URL that launches the Patient Portal where patients can view an online version of statements and/or make a payment. Set the text message and default mode selections in Billing Defaults. Only an option when Integrated Texting Feature in enabled. See Online Payment Management(1563).

- **General Message:** Shows at the bottom of the statement in addition to dunning messages and appointment information.

Undo Billing: See Billing List, Unsending Bills.

Useful Reports
The following reports may be useful for Billing(504) to catch anything you have missed.

- **Aging of Accounts Receivable (A/R) Report** (1308):
  - Determine which patients need their billing type changed to pre-collections or collections, then follow-up as needed.
  - Remember, the Aging calculations are based on the entire account balance not just the patient portion.

- **Finance Charge Report** (1314): See which accounts had Billing/Finance Charges posted.

- **Payment Plans Report** (1321): A list of patients on a payment plan that have amounts due within the next 10 days.

Billing List
In Billing(504), at the bottom, click Create List.
Batch Statements generated via the billing list can be printed, sent to an electronic billing processing service, or emailed directly from Open Dental.

Verify Billing (determines which statements are generated).

Select one or more clinics to filter the billing list by clinic, or select All to generate statements for all clinics. If All, optionally apply default billing filter options, dunning messages, and general messages to statements in the billing list (Use clinic default billing options).

Click Create List. All guarantors that meet the billing option criteria will list.

Sort and Filter Options:
- **Unsent/Sent:** Toggle the list to view sent or unsent statements.
- **Order by:** Sort statements by billing type or patient name.
- **Clinic:** Sort by Clinics.
- **Start/End Date:** Filter by statement date. Click Refresh to apply any date changes.

Other Options
- Double click a statement to view the Statement Window.
- **Edit Selected:** Edit several bills at once. Highlight the bills then click Edit Selected. Any changes affect all selected bills. To only change a single statement, ctrl + click a statement from the selection to edit.
- **Defaults:** Opens limited view of Billing Defaults window in order to modify Electronic Billing credentials (e.g. password/username) without clearing the list of statements.
- **Print List:** Print the list of bills (not individual statements).
- Right click on a row and click Go To to select the patient's account. The bills will show as unsent statements in individual accounts. The billing list window will remain open.
Highlight the statements to send. By default all statements are selected. Click None to clear all selections or click All to select all rows again.

If emailing statements from Open Dental, select the _Email From_ address.

Click Send. Statements will be generated and/or sent based on their Mode.

**Email:** To securely email statements, see [Electronic Billing](514). Regular email is not a secure method of sending statements (PHI).

Email is a patient’s default mode when their billing type is an email billing type (in [Definitions: Billing Types](850), E has been entered for E = Email bill). These statements will be emailed directly from the _Email From_ address. The statement will be attached to the email as a PDF (Adobe Acrobat) and the default email message will be used. If using Clinics and Practice/Clinic is the Email From, the email address of the patient's clinic is used. If there is no clinic email, the practice default is used ([Email Setup](747)). If a patient's email address is missing, that bill will be skipped and you will be notified.

**Mail:** The default mode for all non-email billing types (when electronic billing is turned off). These statements will be generated as one PDF file and previewed on-screen, sorted by clinic in alphabetical order by patient last name. Click Print to send the statements to the printer. Printed statements are designed to be printed on standard perforated billing paper and to fit inside a standard window envelope. Envelopes and billing paper may be ordered from many companies. We have found FormSource to have good service and reliability. See their [Open Dental Healthcare Form Price List](847).

**Electronic:** The default mode for all non-email billing types when electronic billing is turned on. These statements will be sent to the electronic billing processing service.

**InPerson:** The mode for unsent statements generated from the Account module. These statements are generated as a PDF file then previewed on-screen. Click Print to send the statements to the printer.

To send an additional text message to patients when sending statements from the billing list, see Billing Options, **Send text messages for these modes**. The text message can optionally include a clickable URL that launches the Patient Portal Sign in window. See [Online Payment Management](1563).

- **Note:** Do not open other windows while sending statements. Doing so will cause sending to pause.
- Once bills are successfully sent or generated, a confirmation message will show and a statement line item will be added to the guarantor's patient account ledger.
- If sending electronic billing and you have opted to generate PDF copies of the statements, they will generate and save in each patient's Images module, Statement folder.
- If a payment is posted to the account after the statement is generated, but before it is sent, aging will be updated but the dunning messages will not. This is typically not an issue if you send your statements immediately.

**Billing Statement Progress**

A progress window may display while sending, if the preference is turned on in [Manage Module Preferences](744). This is useful for large offices that send many batches of statements an once. You can also set the number of statements in a batch.
Overall: Indicates percentage of progress towards all sending statements.

Batch: Indicates percentage of progress towards printing the batches of statements.

Statement: Indicates the percentage of progress towards printing individual statements in the batch.

Progress Log: Displays a real-time log while statements are sending.

Pause/Resume: Click Pause to stop progress, finish the current statement to PDF, then send the current batch if applicable. Electronic billing statements will not be sent. Click Resume to keep sending statements.

Cancel: Finish the current batch and close the Billing Statement Progress window. The Bills window locks until the batch is finished. Electronic billing statements will not be sent.

Unsending Bills
If something went wrong during the printing process, you can unsend bills to reprint.
1. Click the Sent radio button at the top of the Bills window to show all sent bills.
2. Highlight all printed bills you want to unsend, then click Edit Selected.
3. Uncheck the Sent box. This setting will apply to all selected bills.
4. Click OK to return to the Billing List. Click the Unsent radio button to see all the bills. If you can't find the bill you are looking for, make sure the date range is inclusive enough.

Questions and Answers
How do I change the delivery mode for statements?
Highlight the statements you want to change, then click Edit Selected. On the Statement window, select the mode, then click OK. This will change the mode for statements in this billing list only. To permanently change the default delivery mode for a patient, change their billing type (Edit Patient Information Window) or change electronic billing settings (Billing Defaults).

Billing Defaults
In Billing(504), click Defaults.
Alternatively, in the **Billing List** (507), at the lower right, click Defaults for a limited view that only allows changing the Electronic Billing section.
In addition to the above defaults, there are more in Manage Module Preferences (744).

**Start Date Last ... Days:** The number of days of account history that will show on each statement. This value will be used to calculate the default Start Date on the main Billing Options window. For example, if Start Date Last is 45 days, then the start date printed on the statement will be 45 days from the date the statement is generated. Any transactions completed prior to this date will be totaled as a single line item, Balance Brought Forward at the top of the patient account grid.

**Show all transactions since zero balance:** If checked, all transactions since the last date the account balance was zero will print on the statement.

**Intermingle family members:** Determines how family account history is grouped on statements. This setting also determines the default setting for the Intermingle box on the main Billing Options window.
- If checked, family members will be mixed together on the statement and transactions will be ordered by date.
- If unchecked, each family member will have their own section on the statement with a total.

*Note: Electronic Billing (statements by a third party) are always intermingled.*

**General Message:** The default message that shows at the bottom of statements (and above the dunning message) generated using the billing list. The only variable available for this field is [installplan]. There is a 500 character limit (including the installment plan terms if used).

**Electronic Billing:** See Electronic Billing (514).

**Email Statements:** The default subject and message for statements that are emailed via the billing list or Account module. The following variables are available:
- [monthlyCardsOnFile] - the customers credit cards on file. The first 12 digits will be masked, and the last four digits will show, followed by expiration date, e.g. XXXX-XXXX-XXXX-1234_exp:01/01. Multiple cards will be separated by commas.
- [nameF] - guarantor's first name and preferred name.
- [nameFL] - guarantor's first, preferred and last name.
- [nameFlnoPref] - guarantor's first and last name only (no preferred name).
- [namePref] - guarantor's preferred name.
- [PatNum] - patient number.
- [currentMonth] - the current month.
- [StatementURL] - Include a clickable URL patients can use to launch the Patient Portal Sign in window where they can view online versions of statements and/or make a payment. See Online Payment Management (1563).

**Invoice Note:** The default note that will appear on Invoice (272) sent in the Account module.

**SMS Statements:** The default message for SMS (text) messages sent via the billing list. The following variables are available.
- [nameF] - guarantor's first name and preferred name.
- [namePref] - guarantor's preferred name.
- [PatNum] - patient number.
- [currentMonth] - the current month.
- [OfficeName] – the name of the practice.
- [OfficePhone] – the practice phone number.
- [StatementURL] - Include a clickable URL patients can use to to launch the Patient Portal Sign in window where they can view online versions of statements and/or make a payment. Example: www.patientviewer.com/statements/345Ydm.

**Send text message for these modes:** Set the default modes to send additional text messages to when generating statements from the billing list. The text message can include a clickable link the patient can use to make an online payment. Integrated Texting Feature must also be enabled and patient must be set to accept text messages.
Dunning Messages
In Billing(504), at the right, below the Dunning Messages grid, click Setup Dunning.

Dunning messages are notes and email messages that show on Billing(504) statements generated via the Billing List(507). The messages are generated based on account aging, insurance pending, billing type, or a combination of these criteria.

Example: Create a dunning message that applies a precollections warning in the statement bold note for accounts with a balance aged over 90 days. Additionally, set the dunning message to include a precollections email message.

Messages that meet the filter criteria will list. Dunning messages can be filtered by clinic then sorted by criteria complexity: messages with more general criteria appear higher in the list and messages with stricter criteria appear lower. The first message that matches the billing criteria will be used, starting from the bottom up (lower listed messages take precedence).

- Only one dunning message will be used on any bill.
- The dunning message Email Statement template overrides the Billing Defaults, Email Statements template.
- If a Billing Defaults, General Message exists, it will appear on the statement note above any dunning message.
- Dunning messages do not show when a Single Statement(269) is generated.

Note: To print and email the same statement, we recommend copying the email and/or statement dunning message to a Quick Paste Note(1088). Use the statement generated via the Bills list to email the dunning message. Manually generate a single statement from the patient’s account, insert the quick paste note, then print and mail it.

Add or Edit Dunning Messages
Click Add to create a new dunning message. Double click an existing message to edit.
Note: To copy an existing message, highlight it, click Duplicate, then edit its criteria.
Billing Type: Highlight the billing type(s) to assign the message to. Customize options in Definitions: Billing Types(850). Billing type is set on the Edit Patient Information(62).

Age of Account: Select the account age the message will apply to. See Aging(1423) for details about how aging is calculated.

Days in Adv: Enter a value if you want to trigger the dunning message a certain number of days before an account reaches an aging bucket. If 0, the message will be triggered at day 30, 60, or 90, depending on age of account selected.

Insurance Payment Pending: Select whether to include patients who have insurance payments pending (yes), exclude them (no), or if it doesn't matter.

Statement Notes: Enter the message. Text entered as a Message appears once at the bottom of the statement. Text entered as a Bold Message appears in bold red at the top and bottom of the statement. To edit placement of statement notes, See Statement Layout(1186).

Super Family: Check this box if the dunning message only applies to superfamil heads.

Clinic: Select the clinic this dunning message will apply to.

Email Statement Override: Enter the subject and/or message body for emailed statements. Variables can be used. This message will override the Billing Defaults email message.

Electronic Billing
In Billing Defaults(510), in the middle, is the Electronic Billing section.
Electronic Billing (504) is a way to send patient Statements (269) electronically to a third party billing service. Open Dental recommends and supports both DentalXChange and EDS for electronic billing. Other third party options are available to use at your discretion.

Note: If you select an option other than No electronic billing, when you generate the billing list, the default delivery mode for statements will be electronic. However, if a patient has a billing type that is designated as E (email), the default delivery mode will still be Email (not electronic).

There are multiple options for sending out statements:

- **No electronic billing**: Does not send statements to a third party. This option will allow you to create and print statements on your own.
- **DentalXChange**: See DentalXChange Patient Statements. DentalXChange picks up the statements from Open Dental, converts them into their own format, then mails these to the patient's on your behalf.
- **Output to File**: Save statements as an XML file to your selected Output Path. Maximum number of statements per batch from Manage Module Preferences (744) will be ignored. Third parties can pick up the XMLs from your file path to process.
- **ClaimX/ExtraDent**: Contact ClaimX E-Claims (659) for assistance.
- **EDS**: Save statements to the Output Path for Electronic Dental Services (666) to pick up and process.

The other fields which are editable depend on the electronic billing option selected:

- **Credit Card Choices**: Send credit card choice information with the statement information.
- **Vendor ID**: Vendor ID, if needed. For DentalXChange, this is 68.
- **Vendor PMS Code**: Vendor PMS code, if needed. For DentalXChange, this is 144.
- **Account Number**: Account number, required by DentalXChange.
- **User Name**: User name, required for DentalXChange.
- **Password**: Password, required for DentalXChange.
- **Output Path vs URL Override**: The label changes depending on the electronic billing option selected. Statements will be saved or uploaded to this location by default.
  - If DentalXChange, the label is URL Override and the default path is https://claimconnect.dentalexchange.com/dci/upload.svl
  - Otherwise the label is Output Path and a valid path is required. Only EDS has a default path (C:\EDS\Statements).
- **Generate PDF**: For DentalXChange or ClaimX/ExtraDent only. Determines whether or not a PDF version of each statement will be generated and saved in the Images module, statements folder. We recommend always generating a PDF so that you have a record of statement information sent to the patient.
- **Practice Address**: Select the address to send as the practice address. Entered in Practice Setup (931) or Clinic Setup (1224).
- **Remit Address**: Select the remit (billing) address. Entered in Practice Setup (931) or Clinic Setup (1224).
- **Clinic**: If using Clinics, the clinic name.

  - Note: If the currently logged on user is restricted by clinic, only the clinic they have access to will show in the Clinic dropdown.
  - If Unassigned/Default credentials match other clinic settings, and Unassigned/Default credentials are modified, the edits will affect the other clinics as well. To unlink a clinic from Unassigned/Default, change the clinic's credentials. Then, any changes made to Unassigned/Default will no longer affect the clinic.
Additional third party companies may be able to receive electronic statements however we are not integrated with them. Contact the billing service for more information.

Deposit Slip
Deposits slips are for patient and insurance payments.

In the Manage Module (487), click Deposits.

A dated list of all deposits ever made will show. Use the Clinic drop down menu to filter the list by Clinics (1505). The default selection is the clinic selected in the main menu.

For each deposit, a deposit slip can be printed with your bank account number to take to the bank (see Deposit Slip Layout (1158) to customize deposit slips). Set up Automatic Deposit Entries in the Accounting (546) system to track bank
account deposits (see Accounting Setup(551)). To also create deposits in QuickBooks, see QuickBooks(548) for set up instructions.

- The internal (default) deposit slip is designed to print onto preprinted QuickBooks forms and can only include 18 payments per slip. The top third is included with the bank deposit and preprints bank account information. The bottom 2/3 is a detailed report that is kept for records.
- In the list of custom sheets, the top-most deposit slip will be used for printing. If no custom deposit slip exists, the internal deposit slip is used.
- To enable auto-deposits for claims, see Manage Module Preferences(744), Insurance Payments: Show Auto Deposit.

Creating and Printing Deposit Slips
Click Add to create a new deposit. The Edit Deposit Slip window will open.

![Edit Deposit Slip Window]

**Patient Payments:** A list of Payments(158) that are not attached to a deposit (sorted by payment date, then date entered).

**Insurance Payments:** A list of Claim Payments(231) that are not attached to a deposit (sorted by payment date, then date entered).

By default, all payments are highlighted. Deselect any payments to exclude them from this deposit (ctrl + left-click) or filter the list by changing the criteria under Show (only shows when a new deposit is added). After changing the filter criteria, click Refresh to update the list.

- **Start Date:** Only payments made since this date will be available to include on the deposit.
  
  Note: If you change the date and click Refresh, the refreshed date will be the default start date for the next deposit.
Clinic: Filter the list to only include payments made to a specific clinic. The default clinic is the clinic selected in the main menu.

Patient Payment Types: Highlight the patient payment types to include. Payment types will not show if they are marked N in Definitions: Payment Types(879).

Insurance Payment Types: Highlight the insurance payment types to include. Payment types will not show if they are marked N in Definitions: Insurance Payment Types(872).

Also search the deposit for a specific payment:

Search Check Number: Search payments in the deposit by check number.
Search Amount: Search payments in the deposit by payment amount.

Enter deposit information in the upper right:

Date: Today's date by default.
Amount: Auto-calculated based on selected payments.
ItemCount: Total number of deposit line items selected.
Bank Account Info: By default is the bank account information as entered on the Edit Practice Info window (see Practice Setup(931)) or Edit Clinic window for clinics (see Clinic List(1223)).
Memo: A place to enter any notes specific to this deposit.
Deposit into Account: This option only shows if you have set up Accounting. Click the drop down to select an account to deposit into.

When the deposit is ready, there are a few options before saving:

Print: Print deposit slips directly without generating a preview (does not save).
Create PDF: Generate a PDF of the deposit slip (does not save).
Email PDF: Opens the Edit Email Message window (see Email Message Edit(1656)) and automatically attaches a PDF of the deposit slip (does not save).

Click OK, to save and lock the deposit. The Edit Deposit Slip window will close.

Note: Deleting a deposit only deletes the deposit, not payments. Payments will remain unattached for future deposits.

QuickBooks
To send deposits to QuickBooks:

1. Create the deposit.
2. Click Send QB.
3. Select the desired deposit and income account for this deposit.

Note: When a deposit is sent to QuickBooks, historical information about the accounts used is not kept. Instead look in QuickBooks.

You have the option of sending deposits to Class Refs in QuickBooks for clinics. To enable this option and define Class Ref options, see QuickBooks, Enable QuickBooks Class Refs. When enabled, there will be a Class dropdown on the Edit Deposit Slip window:

Class

To send deposits to a specific Class Ref in QuickBooks:

1. Create the deposit.
2. Select the clinic.
3. Click the Class dropdown to select the Class Ref. The available options are determined by the Class Refs added on the Setup Accounting window.
4. Click OK or Send QB.
5. Select the desired deposit and income account for this deposit.

A message will let you know that the deposit was successfully sent to QuickBooks.

Correct a Deposit
To correct a deposit follow these steps:
- Gather all physical documentation regarding the deposit.
- Print the current deposit slip in Open Dental for your records.
- Open the deposit, then click Delete to delete it. If you are using the Accounting feature deleting the deposit will also remove the transaction from the Transaction History.

Note: If you change or delete a deposit, you need to manually make the same change in QuickBooks.

- Manually go through and correct the claim payments, check amounts, or anything that was causing the deposit to be incorrect.
- Create a new deposit (see steps 1 - 5 above).

Hint: It is easiest to complete all deposits first, then make corrections at the end. This way all remaining payments can easily be identified as the payments to attach to the corrected deposit.

Supply Inventory
Use supply inventory to keep track of suppliers, equipment, supplies, and orders.

In the Manage Module(487), click Supply Inventory.
There is a menu across the top and three buttons.

- **Suppliers**: Set up suppliers. This must be done before you can add supplies or orders. See Suppliers(526).
- **Categories**: Define supply categories in Definitions: Supply Categories(890). This must be done before you can add supplies or orders.
- **Equipment**: Equipment(521) for payment of property taxes.
- **Orders**: Supply Orders(522).
- **Supplies**: Maintain a main Supplies(524) used by the practice.

The Supplies Needed list is completely independent of any supplier or the main supply list. It is a free-form list where any staff can quickly jot down an item that is running low. The person responsible for ordering supplies should review this list. Once a supply is added to an order, it should be deleted.

Click Add to enter a new item, or double-click an item to edit or delete.
Equipment
The purpose of this feature is to track equipment for payment of property taxes.

In the Supply Inventory (519) window, click Equipment.

SN/Descript/Loc: Filter the list by serial number, description or location.

Date Range: Filter the list by specific dates. Click Refresh to load.

Purchased, Sold, All: Filter the equipment view.

Click Add to enter a new equipment item, or double click an item to edit.

Click OK to save.
The serial number is automatically generated. You can physically label the equipment with the serial number for better tracking. Click **Generate** to automatically assign a new serial number. The serial number field can also be cleared or replaced with a different serial number. Serial numbers cannot be duplicated.

**Supply Orders**

The purpose of this feature is to track supply orders.

In the **Supply Inventory(519)** window, click Orders.
The **Order History** lists pending and recent orders. Click the supplier dropdown to filter the list by supplier. Highlight an order and all the associated supplies will list under **Supplies on one Order**. To edit an order's properties (date placed and note) double click on the order. To add supplies to the selected order, click Add. To edit a supply's quantity or price per unit, double click on the supply item. Alternatively, you can click in the Qty and/or Price/Unit cells to edit the amount. Changes made to prices here do not affect the main supply list.

**Add a New Order**

1. Click the **Supplier** dropdown and select a supplier.
2. Click **New Order**. A new pending order will show in the **Order History** list, and it should be highlighted. Click Add and select the supply, or add a new one.
3. Click OK, then repeat until all supplies are added and the order is complete. As you add supplies, the items will list in the **Supplies on one Order** grid.

Note: Items manually added to an order will default to a quantity of one and the price from the main supply list. Edit as required.

4. Once all items have been added, double click on the pending order in the **Order History**.
5. **Date Placed** on new orders will default to today's date. Edit as required, or delete for orders not sent yet. Once a date is entered, the order is no longer considered pending. The Total Amount automatically calculates based on price and quantity entered. Any shipping charges can also be recorded. Enter a note if desired.

6. For tracking purposes a User can be selected from the Placed By dropdown. This will default to the currently logged in user when the Order is created, but will only save once a Date Placed has been entered. Unset orders will always default to "none".

   Note: This is not a security field and can be edited at any time after order has been sent.

7. Click OK.

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**Supplies**

This is the main list of supplies used by the practice. Supplies must be entered before they can be ordered.

In the [Supply Inventory](519) window, click Supplies.
By default, supplies are listed alphabetically; first by category, then by description. Any supply field can also be searched.

**Add**: Select a supplier from the dropdown, then click Add.

**Show Shopping List**: Check to view supplies that have lower on hand quantity than stock quantity.

**Show Hidden**: Check to view supplies marked hidden.

**Add to Order**: With Show Shopping List checked click to create a new order for all items showing in grid for selected Supplier. Quantity for each item will calculate based on Level Desired amount less the Level on Hand.

**Search**: Enter the criteria. The list will update as you type.

**Supplier**: Click the dropdown to filter by supplier.

**Reorder**: Highlight a supply, then click the up or down arrow.

Double click on a supply to edit.

**Category**: Select the category the supply will be sorted under. Define categories in Definitions: Supply Categories(890).
Catalog Item Number: Enter the catalog number.

Description: Enter a readable description and optionally include the quantity per unit.

Level Desired: Enter how many units are normally kept in stock. This value appears in the StockQty column on the main supply list.

Level on Hand: Enter how many units are in stock. This value appears in the OnHandQty column on the main supply list.

Price: Enter the cost of the item.

Hidden: Mark a supply as hidden so it no longer appears in the supplies list. Supplies that have been placed in an order can only be hidden, not deleted.

Suppliers
In the Supply Inventory window, click Suppliers.

Suppliers must be setup before you can add supplies to the Supplies or place Orders.

Click Add or double click on an existing supplier to edit.
Enter the supplier’s information.

Click OK to save.

**TSI Collections**

In the Manage Module(487), click **tsi Collections**.
Transworld Systems Inc. (TSI) offers billing and collection services to dental practices. A TSI interface is integrated with Open Dental so you can manage past due accounts from Open Dental.

- Send past due accounts to TSI.
- Manage accounts, suspend or cancel collections.
- Accept payments directly through Transworld.

Setup: TSI Setup(1078)

Related Links:
- TSI Sent Accounts(530)
- TSI Excluded Accounts(532)
- TSI Payments(534)
- TSI History(533)
- Webinar: TSI Collections Setup
- Website: www.tsico.com

Basic Workflow:
1. Set up TSI integration in Open Dental.
2. Use Open Dental’s Accounts Receivable Manager to identify overdue accounts and send them to TSI.
3. Once sent, TSI will manage all billing and collection activity for the account. Any transactions entered in Open Dental (e.g. payments, charges) will be sent to TSI on a regular basis using the OpenDentalService.

Send Past Due Accounts to TSI
1. Highlight the guarantors to send to TSI. Click All to select all guarantors. Click None to deselect all guarantors.
2. Under Account Placement, select the type of TSI account to send to.
   - Accelerator: Use for accounts less than 90 days old.
   - Profit Recovery: Use for accounts between 91 days and 6 months old.
   - Collection: Use for accounts older than 6 months.
Note: If a user selects the wrong Demand Type for an account, a warning popup message will appear asking to select the correct type.

3. Click Send to TSI.
   - The C billing type will automatically be assigned to the sent accounts.
   - TSI will begin managing billing and collection activity.

Unsent Accounts Tab
Open Dental aging will run and all guarantors who have a balance based on the account filter criteria, and have not yet been sent to TSI, will list on the Unsent Accounts tab. Accounts highlighted in red indicate the guarantor has an invalid birthdate entered or is under the age of 18.

**Account Filters:** Change the filter criteria as needed. To save criteria as the default for the next time you run the report, click Save as Default.
- **Clinics:** Only available when clinics is turned on. Filter by guarantor's clinic. Defaults to the clinic selected in the main menu. Click the dropdown to change.
- **Providers:** Filter by guarantor's primary provider. Click the dropdown to change.
- **Billing Types:** Filter by guarantor's billing type. Click the dropdown to change.
- **Account Age:** Filter by account age.
- **Minimum Balance:** Only show guarantors who have a balance over a specific amount (e.g. only show accounts with a balance over $25).
- **Days Since Last Payment:** Only include guarantors who have not made a payment in a specific amount of days (e.g. only show guarantors who have not made a payment in the last 90 days).
- **Exclude if insurance pending:** Check this box to not show guarantors who currently have an outstanding claim.
- **Exclude if unsent procedures:** Check this box to not show guarantors who have procedures in their account that have not yet been sent on a claim to insurance.
- **Exclude bad addresses (no zipcode):** Check this box to not show guarantors who have no zip code.
- **Show PatNums:** Show patient numbers next to guarantor name. Defaults to the setting in Report Setup: Misc Settings(1096) for Show PatNum.

TSI C Billing Type:
- All family members associated with accounts sent to TSI will be assigned the C billing type as an identifier.
- There should only be one C billing type. If there are multiple, the C billing type listed first will be assigned.
- TSI will send statements on your behalf for patients with the C billing type. Exclude this billing type when running billing so the patient does not receive duplicate statements.
- Do not manually assign the C billing type to any patient. Manual assignment will not initiate TSI account management. Thus, the account could fall through the cracks.
- Do not manually change a patient's billing type from the C billing type to another. Manual changes will not stop TSI account management, but will stop account syncing that could result in double, yet different statements.

Guarantors - Not Sent to TSI: Add or remove columns in Display Fields(900), A/R Manager Unsent Grid.
- **Guarantor:** The account guarantor.
- **Clinic:** The guarantor's clinic.
- **Prov:** The guarantor's primary provider.
- **Billing Type:** The guarantor's current billing type.
- **0-30:** The balance that is 0 - 30 days overdue.
- **31-60 Days:** The balance that is 31 - 60 days overdue.
- **61-90 Days:** The balance that is 61 - 90 days overdue.
- **&gt;90 Days:** The balance that is more than 90 days overdue.
- **Total:** The total balance due.
- **-Ins Est:** Any pending insurance payment estimates.
- **=Patient:** The estimated patient portion due.
- **PayPlanDue:** Payment plan due amounts.
- **Date Last Pay:** The date of the last payment of any family member on the account.
- **Date Time Suspended:** If the account is currently suspended with Transworld, the date and time when it was suspended.
- **Last Proc:** Date of last completed procedure for the family.
- **Date Bal Began**: Date the patient balance began.
- **Days Bal Began**: Number of days ago the patient balance began.

**Guarantor Count**: Total number of guarantor accounts in list.

**Total**: Total sum of accounts for each column.

**tsi OCP**: Click to launch the TSI Online Client Portal.

Right-click on a guarantor, then select Go To to jump to their Open Dental account. Click **Run Aging** to manually run and update aging.

---

**TSI Sent Accounts**

Once an account has been sent to TSI for billing and collection management, it will list in the Sent Accounts tab.

In **TSI Collections** (527), click the **Sent Accounts** tab.

Note: Accounts listed here are determined by a **Billing Type** (850) marked with C (for collections). If you have modified an existing billing type to add a C, or have manually changed the billing type on accounts outside of the TSI interface, guarantors who have not yet been sent to TSI may be listed.

For this reason we recommend only using a single billing type marked C, and only changing the billing status of accounts being sent to TSI from the Unsent Accounts tab.

**Account Filters**: To save criteria as the default for the next time you run the report, click **Save as Default**.
- **Clinics**: Only available when clinics is turned on. Defaults to the clinic selected in the main menu. Click the dropdown to change.
- **Providers**: Filter by provider (which provider?). Click the dropdown to change.
- **Last Trans Type**: Filter by the type of transaction that last occurred. Options include:
  - Cancel: Debt collection activity for this account has been cancelled.
  - Credit Adjustment
  - Debit Adjustment:
    - Paid in Full: Account has been paid in full.
    - Placement: Account was recently sent to TSI to begin debt collection.
    - Partial Payment: Guarantor made a partial payment but a balance remains.
    - Paid in Full, Thank You: guarantor paid the total overdue balance and a thank you letter was sent.
    - Reinstatement:
      - Suspend: Debt collection activity for this account has been suspended.
  - None: no filter based on last transaction.
- **Account Age**: Filter by account age.
- **Minimum Balance**: Only show guarantors who have a balance over a specific amount (e.g. only show accounts with a balance over $25).
- **Days Since Last Payment**: Only include guarantors who have not made a payment in a specific amount of days (e.g. only show guarantors who have not made a payment in the last 90 days).
- **Show PatNums**: Show patient numbers next to guarantor’s name. Defaults to the setting in Report Setup: Misc Settings (1096) for Show PatNum.

**Guarantors - Sent to TSI**: Add or remove columns in Display Fields(900), A/R Manager Sent Grid.

**Suspend TSI Billing and Collection Activity**
1. Under Account Status Updates, click the New Status dropdown, then select Suspend.
2. Click the Billing Type dropdown and select the billing type to assign to the suspended accounts.
3. Click Update TSI to send the information to TSI.

**Note:**
If the patient is sent back to TSI within 50 days of their suspension date, their account will be reinstated. If sent after 50 days, it will be sent as a new account to TSI.

The guarantor will be removed from the Sent Accounts tab. The suspended date and time will list on the Unsent tab under DateTime Suspended.

**Reinstate a Suspended Account**
1. On the Accounts Receivables Manager, Unsent Accounts tab, locate and highlight the suspended account(s).
2. Click Send to TSI.

The guarantor will move to the Sent Accounts tab and the reinstatement date and time will list under Last Transaction.

**Cancel TSI Billing and Collection Activity**
1. On the Accounts Receivables Manager, Sent Accounts tab, select the Guarantor(s).
2. Under Account Status Updates, click the New Status dropdown, then select Cancel.
3. Click the Billing Type dropdown and select the billing type to assign to the cancelled accounts.
4. Click Update TSI to send the information to TSI.

The guarantor will be removed from the Sent Accounts tab.
Payment Plans
If you create a Payment Plan for a patient whose guarantor has been sent to TSI a warning will display that a message will be sent to suspend the account with TSI. If you choose to continue the TSI account will be set to Suspended. After 50 days the TSI account will be automatically cancelled.

If the office decides to send the patient back to TSI for collections, the payment plan must be deleted before reinstateing the account with TSI.

TSI Excluded Accounts
Accounts that have specifically been excluded from TSI Collections will list in the Excluded Accounts tab.

In TSI Collections(527), click the Excluded Accounts tab.

The Excluded Accounts tab lists accounts that have been marked as excluded from collections by right-clicking on a guarantor. This will give the account a CE billing type from Definitions: Billing Types(850).

Note: If multiple CE billing types have been created, only guarantors assigned the first in the list will be included in the Excluded Accounts tab.

Account Filters: Change the filter criteria as needed. To save criteria as the default for the next time you run the report, click Save as Default.
- Providers: Filter by guarantor's primary provider. Click the dropdown to change.
- Account Age: Filter by account age.
- Minimum Balance: Only show guarantors who have a balance over a specific amount (e.g. only show accounts with a balance over $25).
- Days Since Last Payment: Only include guarantors who have not made a payment in a specific amount of days (e.g. only show guarantors who have not made a payment in the last 90 days).
- Exclude if insurance pending: Check this box to not show guarantors who currently have an outstanding claim.
- Exclude if unsent procedures: Check this box to not show guarantors who have procedures in their account that have not yet been sent on a claim to insurance.
• **Exclude bad addresses (no zipcode):** Check this box to not show guarantors who have no zip code.

• **Show PatNums:** Show patient numbers next to guarantor name. Defaults to the setting in Report Setup: Misc Settings (1096) for *Show PatNum*.

Excluded accounts can be sent back to the Unsent list by right-clicking and selecting **Mark Unsent**.

**Guarantors (Excluded) - Not Sent to TSI:** Add or remove columns in Display Fields(900), A/R Manager Excluded Grid.

• **Guarantor:** The account guarantor.
• **Prov:** The guarantor's primary provider.
• **Billing Type:** The guarantor's current billing type.
• **0-30:** The balance that is 0 - 30 days overdue.
• **31-60 Days:** The balance that is 31 - 60 days overdue.
• **61-90 Days:** The balance that is 61 - 90 days overdue.
• **&gt;90 Days:** The balance that is more than 90 days overdue.
• **Total:** The total balance due.
• **-Ins Est:** Any pending insurance payment estimates.
• **=Patient:** The estimated patient portion due.
• **PayPlayDue:** Payment plan due amounts.
• **Date Last Pay:** The date of the last payment of any family member on the account.
• **Date Time Suspended:** If the account is currently suspended with Transworld, the date and time when it was suspended.

**Count:** Total number of guarantor accounts in list.

**Total:** Total sum of accounts for each column.

**tsi OCP:** Click to launch the TSI Online Client Portal.

Right-click on a guarantor, then select Go To to jump to their Open Dental account.

Click **Run Aging** to manually run and update aging.

**TSI History**

Users can view a history of accounts sent to TSI.

In TSI Collections(527), click **History**.
Message Filters:

- **From / To**: Select the date range to view history.
- **Patient**: History shows for the selected patient. Leave blank to show all.
- **Current / Find / All**: Select the current patient, find a different patient, or select all patients to view history.
- **Client IDs**: Use the dropdown to filter the history by Client ID type.
- **Account Statuses**: Use the dropdown to filter the history by Account Status.
- **Trans Types**: Use the dropdown to filter the history by Transaction Type.

Raw Message: Use the raw message to understand the message history sent to TSI.

- **Selected Field Name**: Highlight part of the message history to view a field name.
- **Selected Field Details**: Highlight part of the message history to view field details.

Show Patnums: Check this box to include patient numbers in the history.

Click **Refresh** to update the history.

Click **Close** to go back to the TSI window.

---

**TSI Payments**

When a payment is made to an account that is managed by TSI Collections (527) services, you will enter the payment in Open Dental as normal.

- Payments may be made to TSI, who will then send the payment to you for you to enter.
- If a guarantor pays you directly, you can also enter the payment. The information will be sent to TSI using the OpenDentalService at the regular sync time.

- **Note**: It is recommended to create a payment type and adjustment type specific to TSI.
Positive and negative adjustment information is sent to TSI using the OpenDentalService at regular sync time.

Payments made by TSI
When a patient pays TSI, TSI will send the payment to the office after collecting their portion.
1. Go to the patient’s account.
2. Click Payment. You will get the following message:

![Message](image)

3. Select No. This will prevent a message about the payment from being sent to TSI.
4. Enter the amount and complete the payment as usual.
5. In the patient’s account, click Adjustments. You will get the following message:

![Message](image)

6. Select No. This will prevent a message about the adjustment from being sent to TSI.
7. Add a negative adjustment reflecting the portion of the payment kept by TSI. Complete the adjustment as usual.

Payments made by Patient (directly to office)
When a patient pays the office, a message is automatically sent to TSI so they have a record of the payment. The office will send the agreed portion of the payment to TSI.
1. Go to the patient’s account.
2. Click Payment. You will get the following message:
3. Select Yes. This will send a message to TSI about the payment.
4. Enter the full payment amount and complete the payment as usual.
5. Click Payment again to enter TSI’s portion.
6. When prompted with the message above, select No.
7. Enter the portion sent to TSI as a negative amount. (e.g. -100.00) Complete the payment as usual.
8. In the patient’s account, click Adjustments. You will get the following message:

The guarantor of this family has been sent to Transworld for a past due balance. Is this the payment you are applying directly from the debtor or guarantor?

Yes - this payment is directly from the debtor/guarantor
No - this payment is from Transworld

9. Select Yes. This will send a message to TSI about the adjustment.
10. Add a negative adjustment reflecting the portion of the payment kept by TSI. Complete the adjustment as usual.

Tasks Area

Task lists and tasks are managed in the Tasks area, and can be used for office communications, reminders, appointment lists, patient lists, daily, weekly, or monthly check off lists, etc.

In the Manage Module(487), click Tasks.

The task area may also be docked to the bottom or side of the main Open Dental window.

A task list can include nested task lists or tasks.
Tasks lists that have new tasks are flagged with an orange checkbox and the number of new tasks appears in parentheses.

When the Tasks area is docked, you can resize the area by dragging the splitter (the horizontal bar between the tasks area and the rest of the screen). To change docking options, right-click on the splitter, or click Setup, Task.

**Options:** Set task list options.

- **Show Finished Tasks:** If checked, view tasks that have been marked Done in the selected task list.
- **Finished Task Start Date:** View tasks marked Done on or after this date. Enter any date in this field.
- **Sort appointment type task lists by AptDateTime:** If checked, task lists that have Object Type set as Appointment will sort by the appointment's date and time, not the date and time the task list was created.
- **Default tasks to collapsed state:** If checked, tasks that meet the criteria will be collapsed by default.
- **Show Archived Task Lists:** If checked, task lists that have been marked Archived will be shown.

Note: Tasks can also be filtered by Clinic (1224). See Tasks Preferences (1192) to enable.

**Add Task List:** Create a new task list.

**Add Task:** Create a new task. Click the dropdown to add a reminder task.

**Search:** Search for specific tasks. See Task Search (1707).

**Manage Blocks:** Block task popups for specific task lists. Select the lists to block, then click OK. Tasks in selected lists will not pop up, but will still show in the New for User tab until read.

**Unfiltered:** Only visible when Global Filter for Task Lists is enabled in Task Setup. Allows a user to manually filter a task list.

- Default: Use the default filtering option selected in Task Preferences.
- None: Do not filter out tasks in this list.
• Clinic: Filter the list by clinic. Highlight one or more clinics, then click OK.
• Region: Filter the list by region. Highlight one or more regions, then click OK.

Tabs: Click on a tab and its task lists will show.
• for User: Task lists that the current user is subscribed to. Typically includes a user's inbox.
• New for User: See the current user's new tasks and due reminders all at once.
• Open Tasks: Keep track of tasks that have an object type of Patient and are From the currently logged on user. This tab is only visible if Show open tasks for user is checked in Tasks Preferences (1192).
• Patient Tasks: Keep track of tasks that have an object type of Patient and a patient attached. When the attached patient is selected, their tasks will show in this list.
• Main: All shared task lists and inboxes.
• Reminders: View all task reminders regardless of due status. Reminders replace repeating tasks in 16.3 and greater. See Task Reminder (1701).
• Repeating (setup) / By Date / By Week / By Month: Only show when Show legacy repeating tasks is enabled in Task Setup.

Task lists
Click on a task list to see the tasks within.

Right click options:
• Edit Properties: Edit task list options.
• Set Priority: Change the task priority. A task note is added with the user that changed the task and the new task priority (only applies to non-inbox task lists).
• Cut: Cut task list to move into another list.
• Paste: Paste a cut task list into another location.
• Delete: Delete this task list.
• Subscribe: Subscribe to the task list.
• Unsubscribe: Unsubscribe to the task list.
• Archive: Marks list as archived, allows it to be hidden by default.
  o Note: Archiving will archive any child lists.
  o Archived task lists have their Object and Date Type set to None and disassociates any User Inboxes.
  o To show Archived task lists, enable Show Archived Task Lists in Task Options above.
    • When Archived Task Lists are showing, a right-click option to Unarchive will be available. This does not restore Object of Date Type, or User Inbox associations.

Note: If you move a main task list into its own sub-task list, the sub-task list(s) will become main task list(s).

Tasks
Double-click a task to open it. See Task Window (1698).

Right click options:
• Done (affects all users): Mark a task as done.
• Edit Properties: Open task to make edits.
• Set Priority: Change task priority.
• Cut: Cut task to move to another list.
• Copy: Make a copy of the task to move to another list.
• Paste: Paste a cut or copied task into a list.
• Delete: Delete this task.
• Send to Me: Send selected task to your inbox.
• Go To: Go to the patient or appointment associated with the task.
• Mark as Read: Mark task as read.

Task text that is more than 250 characters, has two or more task notes, or one task note more than 250 characters can be expanded or collapsed. The + or - in the +/-column indicates in current state. Click the +/-column header to toggle all tasks between expand or collapse.
- indicates a task that is expanded. Click - to collapse text.

+ indicates a task that is collapsed. Click + to expand.

Set the default state in Task Preferences.

**Task popout count**
The task popout window displays the number of tasks in the selected task list. Hover over the Open Dental icon on the taskbar to view. Task count only shows when the tasks window is open and a task list or tab is selected.

If tasks are not popping up on your screen, ensure the following:
- Task lists allow for popups. Verify tasks lists selected in *Manage Blocks*.
- Your user is assigned to your inbox.
- You are subscribed to the task list.
- You are logged in as your own user.

**Backup Tool**
In the *Manage Module*(487), click Backup.
Use Open Dental's built-in tool to back up data, restore data, or archive data. Also see Backups (541). This tool can back up the following data:

- **Open Dental Database**: The MySQL database where your patient data is stored. By default, it is located at `C:\MySQL\Data\OpenDental\`
- **A to Z Folders**: Scanned or imported files are stored here. Typically `C:\OpenDentImages`. See Paths (824).

Note: Backups should be run from the server that hosts your MySQL database. Running the tool from a workstation will likely result in an error, or the incorrect data being copied.

This tool does not encrypt data, so consider an encrypted device or encryption software to ensure data is protected while in storage. See Encryption of Data at Rest and in Transit To use the backup tool, you must have the security permission Backup.

**Backup Tab**
The Backup tab is used to backup or restore data. To backup your data connect the backup device (e.g. USB encrypted flash drive) to the server.

By default, the A to Z Folder (826) are backed up and restored. To change this and NOT include the A to Z folders in the backup/restore, check the Exclude image folder from backup or restore box.
Verify the database path to back up (Backup database FROM this folder). Typically it is C:\mysql\data. Click Browse to select a different path.

Verify the drive or folder to back up the data to (Backup TO this folder). The letter will differ depending on your computer's drives. In the simplest case, it would be D:\. Click Browse to select a different drive.

Click Backup. A message will display when the backup is complete. If the destination drive does not have enough space for a complete backup, a notification appears and backup stops.

Managed Backups: Central Data Storage is a preferred online backup service. Click the button to see more information; you will not be charged. To remove this button, disable the Central Data Storage CDS Bridge (959) then check Hide Unused Button.

**Managed Backups**

**Restore Data**
You should test backups regularly to make sure they will restore correctly when needed. The location of the restore will depend on your practice. For many, at home will be a practical choice. The name of the backed up database must match the name of the restored database.

**Instructions:**

1. On the restore computer, make sure you have a working copy of Open Dental that runs. If not, install the Trial version and make sure it is working properly.
2. Insert the flash drive in the restore computer.
3. Start Open Dental by running as an administrator, then open the Manage Module.
4. Click Backup.
5. In the Backup window, there are three lines for restore options (below backup options). Click Browse to locate correct paths if needed.
   1. **Restore FROM**: The letter of the flash drive. It is not necessarily the same as the one at the office. In the simplest case, it is D:.
   2. **Restore database TO**: The path to restore the database to.
   3. **Restore A-Z images to this folder**: The path to restore the A to Z Folders to
4. Click Restore. A message will ask if you want to restore from the backup on the flash drive (with date).
5. Click OK and the restore process begins.
6. As soon as the restore is finished, close Open Dental.
7. Start Open Dental again.
8. The Data Paths window will open. In the first line you will see the name of your office server. Change it to the name of your restore computer (C:\OpenDentImages). Leave the other options as they are.
9. Click OK and your Open Dental software should finish opening.

- **Note:** If the restored database version does not match the current version of Open Dental, Open Dental will automatically close and you will have to relaunch.
- If you changed the name of the database from opendental, you must also change it on the new computer before attempting the restore.

**Backups**

Backing up patient data is critical, as well as a requirement for HIPAA compliance. You should establish a regular backup and recovery plan. This will ensure that patient data is protected, even if there is accidental data loss, database corruption, hardware failures, theft, or other disasters (floods, fires, etc).
Backups should be frequent, stored securely, and tested regularly to ensure quality. We suggest backing up data to a high quality encrypted USB flash drive, using an online backup service, or both. Then verify the quality by restoring backups to your home computer or another location.

Note: It is recommended to run an Open Dental Backup only when other users are not working in Open Dental. Otherwise, users may experience a UE: Table 'procedurelog' is read only error that will disappear when the backup is complete.

There are several backup options to consider when making a backup plan.
- **Backup Tool** (539)
- **Online Backups** (543)
- **Manual Backups** (545)

**What to Back Up**

- `\SERVER\mysql\data`: The database that stores patient data.
- `\SERVER\OpenDentImages`: The A to Z Folders (826) that store files you scan or import. See Paths (824).
- Other office documents unrelated to Open Dental.

**Frequency**
At minimum, backups should be made daily. If you at least have good daily backups, then the worst-case scenario is having to re-enter one day of data. Incremental backups throughout the day would be a little bit better, if you have that ability. Backing up while the database is in use is possible, but only with certain software, and it can get complicated.

**Encryption**
Backed-up data should be encrypted so that patient data remains secure, for example in cases of theft or loss. See Encryption of Data at Rest and in Transit.
- Encrypted USB drives: We recommend purchasing a few and rotating them. An example is.
- Hardware Encrypted Drives (Recommended), such as those offered by Apricorn (https://www.apricorn.com/). Data is encrypted by a dedicated processor located on the encrypted drive instead of using the computer's processor. Hardware encryption devices run independently of the operating system and any additional software. Data is protected from unauthorized access by pin numbers.
- Software Encryption, such as BitLocker Encryption. This will entail encrypting the data first, then backing it up. Software encryption uses the computer's resources to encrypt data. Software must be updated, or reinstalled if you change operating systems.

RAID is not a backup solution and should not be relied on for backups or disaster recovery plans.

**Archives**
You also need to keep old copies of some of your backups. You can make separate monthly backups to a different flash drive. When it fills up, put it in storage, and get another one. If you are using imaging, then manually backup the C:\OpenDentImages folder to CDs, DVDs, or removable hard drives.

A good use of archiving would be to use a file versioning systems which allow you to go back to a specific date and time and restore files that might have been accidentally deleted or modified. These programs can typically backup to multiple locations safely and securely.

**Backup Reminder**
See Backup Tool (539).

This window will pop up automatically once per month when starting Open Dental.
This is to remind you to think about Backups(541), because it's an absolutely critical issue that is often neglected.

For each question, you must check at least one answer. Click OK to close the window.

Note: While not recommended, monthly backup reminders can be disabled. See Global Security Settings(1107).

Online Backups
See Backup Tool(539).

Cloud Backups(541) can be a tool in a regular backup and recovery plan. If using a cloud service, these folders should be backed up:

- **mysql\data\** - The database that stores patient data.
- **OpenDentImages\** - The A to Z Folder(826) that store files you scan or import. See Data Paths Setup(824).

As always, backups should be encrypted, and regularly restored to another machine to verify quality.

Be aware that cloud backups are not a perfect solution.

Also see Cloud Hosted Automated Backups.

**Advantages:** Automated, with no action required by user after setup. Off-site, so protected in case of fire, flood, burglary, etc. While we recommend some solutions that we have reviewed, we do not sell backup solutions or directly backup your data for you.

**Disadvantages:** Initial setup and the first backup can be time consuming because the initial backup can be very slow.
While the initial backup could take less than an hour if you are only backing up your database, it can literally take as long as a week if you are including many images. Subsequent backups are incremental, only sending the changed data.

**MySQL Service**: Automated stopping and starting of the MySQL service is not important because backups can safely be done without stopping the MySQL service. You would never restore directly to the live database location, so the backup service is not involved with the actual final move of the restored data to the live location. All of the backup services are good at copying locked files. In the rare case that a locked file causes a failure, it should only affect that one file and should not be a major problem. When restoring a database using the data provided by your backup service, follow these general steps.
1. Restore to a new location (like C:\restored files) or to another machine, not to your live database on your server.
2. Stop the MySQL Service.
3. Make a manual local backup of your current database (if there is one still there).
4. Delete the current database.
5. Place the restored database in the location where your live data was.
6. Turn back on the MySQL service

**Specialized Backup Services**
These companies may provide more specialized solutions or managed backup services that require less technical involvement on the part of the user.

**Central Data Storage** *(recommended)* Central Data Storage with Open Dental
- Meet mandatory requirements for a data backup plan, disaster recovery plan, and emergency mode operation plan
- Managed STaaS (storage as a service)
- Email encryption (CDSmail)
- Confidentiality Agreement (CA)
- Business Associate Agreement (BAA)
- Unlimited storage, archiving, and versions
- Data compression
- File retrieval
- Satisfy 88 of the 168 HIPAA audit controls
- No contracts

**Backup Service Reviews**
Specific backup services are listed here to help customers make informed decisions. Most of the products below have quirks and there are learning curves with each one. Some have been reviewed.

**Carbonite**: In June 2016, Carbonite informed us they are capable of supporting backups of live databases for Server Backup versions. Live database backups are currently untested. While some customers have successfully used Carbonite to restore backups, others have reported corrupt files and even appeared to have databases corrupted by the backup process without even doing a restore.


**iDrive**: Works well, no known complaints from our customers to us. There are multiple interface options, including classic, web, and explorer (virtual drive). It keeps the last 30 versions of every file, only counting the current version when computing your storage usage. Timeline restore allows restoring to a specific historical point. There's also a free backup program (which we have found to be buggy) available on their website that's optimized for backing up to a removable hard drive. Available for trial or purchase: [http://www.idrive.com/p=open_dental](http://www.idrive.com/p=open_dental).

**Mozy**: Works well, no known complaints from our customers to us. The quality seems high, and it comes from a reputable company. It has a rich web management interface, allowing centralized management of backups for multiple computers and offices. The price is very low and you can buy exactly the amount of storage you need and no more. You buy a key for a computer, and then you use that key during installation of the client program to attach that machine to the service. **WARNING.** Do not attempt to use that same key to install on a second machine. You will receive warnings, but are allowed to proceed. If you do, the first machine becomes detached, requiring uninstallation of the client program. Uninstallation requires a computer restart. To restore a backup, the following methods can be used:
- **Backup agent**: If you switch computers, there is a function to replace machines so that the new machine has access to the old machine’s data.
- **Download manager**: Stream data directly to a target location.
• Zip Files: An old method that is used when a permanent archive of files is desired, or when a machine is staged first, then sent to an end-user. The zip file has to be manually unzipped.

Once Mozy is installed, an icon will always be present in the system tray. Free phone support is available 24/7/365. Available for trial or purchase: http://www.mozy.com

SugarSync: Not reviewed, no known complaints from our customers to us. Feature set looks interesting. Has version management built in, keeping the last 5 versions of every file. Charges by storage size and does not charge extra for multiple computers. Automatic multi-computer sync. Remote access using browser. Share folders with others. The shared folders are password protected, but require the other person to sign up for a free trial. Available for trial or purchase: www.sugarsync.com/

Folder Synchronization (for Replication)


SyncToy 2.1: Typically used for the OpenDentImages folder. A free application that synchronizes files and folders between locations. SyncToy has many features, including:
• Synchronizing just the changes once the first synch has been performed making future synchs very fast.
• Use command line options with Windows Task Scheduler to automate SyncToy to run at specified dates/times, e.g. scheduling a backup.
• One-way or two-way synchronization.
• Support on Network Attached Storage (NAS) drives.
• 32bit and 64bit support.


Manual Backups

If not using Open Dental's built in Backup Tool(539) or an online Online Backups(543) service, you can do manual backups. There is also local software that can be installed so that it's not truly manual.

Software

Here are some of our impressions of backup software. Each software has quirks and a learning curve. There is also lots of other very good backup software that we don't mention here. If your IT professional has a favorite, use it.

Backup4all: https://www.backup4all.com/ Get the Pro version for $50. Our favorite features are:
• backup from network share
• backup to network share
• incremental and block-level (partial file) backup
• encryption in zip file
• multiple destinations
• email notification

It also offers cloud backups through the same interface.

Recommend "mirror" uncompressed backups with "fast mirror" option turned on. Otherwise, backups can only be restored through the Backup4all interface. Read their manual to understand the nuances of this setting. Additional incremental backups can also be done separately from the mirrors.

Acronis: Too many things in the system tray and it slows boot time.

Paragon: Seems very powerful, but they have so many products to pick from that it's very confusing. If you have a large organization, it looks like they could scale up easily to provide centralized backups across many computers. Their free version seems to be intentionally hidden from their menu: https://www.paragon-software.com/free/br-free/ Not reviewed, but it looks decent and it gets positive reviews from other reviewers. One problem is that the free version only supports
workstations, not servers. The next step up from the free version would be Backup and Recovery Business, which does not have a price listed.

**Back up Data**
This must be done from the server where your database is located. Connect the backup device (e.g. USB flash drive) into your computer. It would then be recognized as the available drive in My Computer and assigned a drive letter, usually D:. It can be different if the computer has multiple hard drives installed.

The backup software will copy two folders to your flash drive:

What needs to be backed up?

- `\SERVER\mysql\data\`: The database that stores patient data.
- `\SERVER\OpenDentImages\`: The A to Z Folders that store files you scan or import. See Paths(824).

You should try to make sure nobody is using the program during a backup, but you don't need to close the program.

**Note:**
Manual backups should only be done on myISAM databases; not InnoDB.

**Restore Data**
Restore your backup to your home computer to make sure it's a good backup. You will have already installed Open Dental on that computer. The version should be the same as your office computer. Verify versions from Help, Update.

1. Stop the MySQL service as follows:
   - Right click MyComputer, Manage, Services and Applications, Services.
   - Highlight MySQL and stop the service

2. Rename the old database folder. For example, from `C:\mysql\data\opendental\` to `C:\mysql\data\opendentalold02142006\`.

3. Copy the database folder from the backup source to the appropriate location on the main hard drive. For example, from `D:\opendental\` to `C:\mysql\data\opendental\`. Make sure you don't end up with too many layers (e.g. `C:\mysql\data\opendental\opendental\`).

4. (optional) Copy the OpenDentImages folder (the A to Z folders) to the hard drive (e.g. `C:\OpenDentalData\`).

5. Restart the MySQL service.

6. Open the program.

If you have trouble opening the program after restoring, you may need to run the setup.exe stored in your backup in the OpenDentImages folder. If the installed version is newer than the backup version, then you will need to uninstall Open Dental from the control panel before running setup.exe.

Also see [HIPAA](#).

**Accounting**
Open Dental has a built-in accounting tool that can be used independently by small offices.

In the Manage Module(487), click Accounting.
The chart of accounts is a list of the accounts used to organize finances and divide expenses, revenue, assets, liabilities, and equity.

Setup: Set up automated deposit entries and automated payment entries. See Accounting Setup(551).
Lock: Lock all accounting entries on or before a specific date, e.g. when closing out the year. See Accounting Close Year(553).
Reports: Generate and print end of year reports.
• General Ledger Detail: A list of transactions for each account in a date range.
• Balance Sheet: Total asset, liability, and equity as of the date selected.

Add, Edit: Add new or edit (and mark inactive) existing account types.
Export: Save the Chart of Accounts details as a text or Excel file. Change the As of Date to export the Balance totals for the date entered.
Close: Close the Accounting window.

As of Date: Change to view balances on a different day and click Refresh.
Today: Click to refresh the list to show current balances.

Include Inactive Accounts: Include or exclude accounts marked as inactive.
• Check: Shows inactive accounts and their balances as of the date selected.
• Uncheck: Hides inactive accounts and their balances. Unchecked by default.

Chart of Accounts: A list of existing account types and their balance as of today’s date.

To add, edit, or view, Accounting Transactions(556), double-click an account.

Set up the Chart of Accounts
When set up correctly, certain transactions in Open Dental will automatically create accounting transactions in the Chart of Accounts. You can also set up deposits to automatically create accounting transactions in QuickBooks. See QuickBooks(548)

To add a new account, click Add. To edit an existing account, select the account and click Edit.
Description: Enter the account name.
Type: Select the type of account. There are five types of accounts:
- Asset accounts: e.g. practice checking account, equipment, cash box
- Liability accounts: Loans
- Equity accounts: Owner/Practice Contributions/Capital, Retained Earnings
- Income accounts: For accounts receivable (e.g. sources of revenue such as patient or insurance payments)
- Expense accounts: For accounts payable (e.g. expenses such as supplies, utility bills, employee benefits, etc.)
Bank Number: The bank account number to represent this chart of account (typically only for Asset account types).
Inactive: Mark this account inactive to hide it from the Chart of Accounts grid.
Row Color: Set a color to make the row easier to spot in the Chart of Accounts grid. Click on the color box to select a color.
Delete: Removes the account. Accounts with transactions cannot be deleted.

Troubleshooting
See Accounting FAQ(555)

If accounts for automatic payments are set up incorrectly, transactions may be attached to invalid accounts and you may receive an error when trying to view old payments. Follow these steps to identify and fix the transactions.

1. Update(1639) to the latest stable version.
2. In the Main Menu(592), click Tools, Database Maintenance(1434).
3. Click Fix.
4. A message in the log will indicate how many transactions have an invalid account: "Transactions found attached to an invalid account: X. All invalid transactions have been attached to the account called UNKNOWN. They need to be fixed manually."
5. In the Manage module, click Accounting. A new account called UNKNOWN will show. Double click on it to view all transactions attached to an invalid account.
6. For each transaction correct the account.
   1. Double click on the transaction.
   2. Uncheck the Simple box.
   3. In the Splits area, double click on the Unknown account.
   4. Click Change and select the correct account.
   5. Click OK to save the change and close the window.
In Accounting(546), click Setup.

Open Dental has the ability to automatically create accounting transactions for deposits in the QuickBooks accounting software. The bridge was designed using QuickBooks 2012 and may not work with other versions or the online version of QuickBooks.

Follow the instructions below to enable the QuickBooks bridge. Once enabled, see Deposit Slip(516), QuickBooks, for instructions on sending new and old deposits to QuickBooks.

To enable the QuickBooks bridge:

- Install QuickBooks on the local computer, provide access to the company file and log in as an administrator user.
  
  Note: Let QuickBooks run in the background.

- Install QuickBooks Foundation Class: Download QBFC10_0Installer.zip, unzip, and run the installer.

Deposit Software: Select QuickBooks.
**Company File**: Enter the path to your QuickBooks company file. To Browse for the company file, close QuickBooks in the background first. Once added, run QuickBooks in the background again.

**Connect**: Click to open a security window from QuickBooks.
- Select Yes, always. Click Continue.

![QuickBooks - Application with No Certificate](image)

- **List of accounts to deposit to**: Click Add and select the deposit account to add it to the pick list. Accounts entered here will be options when sending a deposit to QuickBooks on the Edit Deposit Slip window.

- **List of income accounts**: Click Add to select the Income Account options available when the deposit transaction is created.
  - Note: If the account you are looking for is not available when you click Add, make sure you have logged in to QuickBooks as a user who has access to all accounts.

- **Enable QuickBooks Class Refs**: This preference is useful for those who want to track deposits by clinic in QuickBooks (Class Refs).
  - Checked: Enable the ability to assign class refs to deposits. A Class List area will show listing the class options that will be available when sending a deposit to QuickBooks.
    - To add a class ref, click Add, select it from the Input dropdown, then click OK.
    - To remove a class ref, highlight it and click Remove.
Unchecked: (old behavior) There will be no Class selection option on the Edit Deposit window.

Click **OK** to save the settings. The next time a deposit is created in Open Dental, a deposit transaction will automatically be created within the QuickBooks company file, using the accounts you choose at the time of creation.

**Technical Details**

Multiple Open Dental Databases: One QuickBooks company file can have multiple Open Dental databases making deposits into it. Each Open Dental database will need to have the settings manually set up in order to start making deposits into the company file. Be sure to make a detailed memo if you need to know which database the deposit came from.

Running QuickBooks in Background: Open Dental will run much faster if QuickBooks is open in the background. Make sure to use the exact same company file path to launch QuickBooks outside of Open Dental otherwise you will receive an error that says "Error: A QuickBooks company data file is already open and it is different from the one requested or there are multiple company files open". Having QuickBooks running in the background significantly cuts down on authentication and communication time for every command that Open Dental sends.

**Edit Application Permissions in QuickBooks:**

1. Open the company file. Go to the Edit menu, choose Preferences, and click Integrated Applications.
2. Click the Company preferences tab.
3. Set the following preferences:
   - Uncheck 'Don't allow any applications to access this company file'.
   - Uncheck 'Notify the user before running any applications whose certificate has expired'.
   - Note: If checked, automatic access will be suspended when the application's certificate expires.
4. Select the appropriate application and click Properties.
5. Change any of the options.
6. If the company file has multiple users and 'Allow this application to login automatically' is checked, select a user for the application to log in as. Although you can permit the application to log in as any user you want, you may want to create a user specifically for the application. This lets you control the type of data the application can access.
7. If necessary, using whatever mechanism is available in the third-party application, set it to communicate with QuickBooks at your chosen time.

**Accounting Setup**

In **Accounting** (546), in the top menu, click **Setup**.
Open Dental should be selected as the Deposit Software.

**Set up Automated Deposit Entries**

When a Deposit Slip (516) is created, an entry goes into an asset account (e.g. checking account) to balance your bank account. A second entry is made in an income account to keep track of the income total. To also create deposits in QuickBooks, see QuickBooks (548) for set up instructions.

**Automatic Deposit Entries**: Select one or more asset account where deposits can be automatically deposited into. Click Add, then double-click an asset account. Added accounts will be options in the Deposit into Account dropdown on the Edit Deposit Slip window. The first one listed will be the default (typically a checking account).

**Income Account**: Select the income account where deposits will be credited to track total income. Click Change, then double-click an income account.

**Set up Automated Payment Entries**
Some payment types that do not use deposit slips (e.g. cash payments or patient refunds) but still need an accounting entry, can be assigned to an asset and income account to create automatic payment entries. Every time the payment type is used, an entry goes into an asset account (e.g. checking account) to balance your bank account and a second entry is made into an income account to keep track of the income total.

**Automated Payment Entries**: Associate a payment type to an asset account. Click Add to open the Edit Auto Pay Entry window and select a payment type from the dropdown menu.

Click Add, then double-click an asset account. Added accounts will be options in the Pay Into Account dropdown on the Payment(153) window.

**Income Account**: Select the income account where the payment types will be credited to track total income. Click Change, then double-click an income account.

If accounts for automatic payments are set up incorrectly, transactions may be attached to invalid accounts and you may receive an error when trying to view old payments. Follow the Accounting(546) troubleshooting steps to identify and fix the transactions.

**Accounting Close Year**

In Accounting(546), in the top menu, click Lock.
When using the Accounting system, there is no close out process. The accounts will never be zeroed out. The asset, liability, and equity accounts will carry over to the next year fully intact. The income and expense accounts are programmed to only show the accumulation since the beginning of the calendar year and does not include previous years.

While there is no close out process, there are some useful end of year reports that may be run (see below). To prevent users from editing accounting entries that may change the historical information on these reports, lock accounting entries before a specific date.

**Lock Accounting Entries**
Only users with the *Security Admin* permission may lock accounting entries.

In the Accounting window, click **Lock** to open the Lock Accounting window and enter the lock date.

Click **OK**. All entries made prior to the entered date will be locked.

**End of Year Reports**
Two reports are available in the accounting section.

- **General Ledger Details**
- **Balance Sheets**

**General Ledger Details:** This is a list of all transactions from all accounts.
1. In the Accounting window, click **Reports** and select General Ledger Details.
2. Use the calendars to select the date range.
3. Click OK to generate the report. See [Complex Report System](1280) for a description of tool buttons.

**Balance Sheet:** This is the total asset, liability, and equity as of the date selected in the main Accounting window.
1. In the Manage module click Accounting.
2. Click Reports and select Balance Sheet.
3. Use the calendar to select the date.
4. Click OK to generate the report. See [Complex Report System](1280) for a description of tool buttons.

On the Balance Sheet two values are shown at the bottom of the Equity section:
- **Retained Earnings:** The sum of the Net Income from all previous years.
- **Net Income:** Income minus Expenses since the beginning of the year for which the report is displayed.

These are very closely related, and they incorporate the income and expense numbers into this report. They are handled automatically rather than requiring end-of-year entries to zero out the income and expense accounts. You are still free to manually enter the closing transactions if that's what you are more familiar with. In that case, when the software does the automatic calculations, it will just be dealing with zero amounts, so they would not have any effect.
Accounting FAQ
Below are answers to frequently asked questions about the Accounting feature in the Manage Module.

What types of accounts can you set up?
- Asset accounts: e.g. practice checking account, equipment, cash box
- Liability accounts: Loans
- Equity accounts: Owner/Practice Contributions/Capital, Retained Earnings
- Income accounts: For accounts receivable (e.g. sources of revenue such as patient or insurance payments)
- Expense accounts: For accounts payable (e.g. expenses such as supplies, utility bills, employee benefits, etc.)

What do I need to do to get started?
1. Setup chart of accounts: Create at least one asset, expense, and income account. These account types are already available but you can edit/hide, delete, or add new ones.
2. Setup automated deposit entries: Assign deposits to an asset and income account so when Deposit Slip are created, an entry is made into both the asset account (e.g. checking account) to balance your bank account and income account to keep track of the income total.
3. Setup automated payment entries: Assign specific payment types that do no use deposit slips (e.g. cash payments, patient refunds) to an asset and income account so when these payment types are created an entry is made into both the asset account and income account.

For detailed instructions, see Accounting Setup.

How do I add an account type to the Chart of Accounts?
In the Manage module, click Accounting, then Add to open the Edit Account window. Enter the description and select a Type.

What is Automatic Payment Entries for on the Setup Accounting window?
It is commonly used for cash payments from patient or patient refunds. When you click Add, you will be prompted to select a payment type and add accounts the cash will be deposited into (we recommend using a second asset account such as Cash Box). Also select an income account so the transactions are included when tracking total income.

Note: Cash box accounts should be treated like a checking account. All money going in and out must be recorded as a deposit to another account or as an expense. If not automatically added, manually enter the accounting transaction in the Cash box account.

A checking account does not make sense as a deposit account since each entry in a checking account is reconciled with a transaction recorded by the bank.

How are deposits assigned to an account?
When you create a new deposit, the account that will receive the deposit is listed under Deposit into Account on the Edit Deposit Slip window. The default account is the first one listed in for Automatic Deposit Entries. You can also manually create a deposit if the income received is not from a patient.

How do I enter a transaction for a payment (e.g. utility payments, rent)?
We recommend entering a negative payment from an asset account like a checking account. It is easier to remember that a negative number here deducts from your asset account balance. If you instead enter the payment from an expense account, the payment amount should always be positive since it adds to the expense total.
1. Double click the account to open it.
2. Click Add.
3. Enter the payment (as a negative number from an asset account, or as a positive number from an expense account).
How do I account for a patient refund?
Patient refunds are entered as a negative patient payment. Create a patient refund payment type (see Definitions: Payment Types) and set up Automatic Payment Entries for the refund type. Every time a refund payment is created, an accounting entry will automatically be made into the assigned asset and income account. If no Automatic Payment Entries are created for the payment type, manually create an entry in credit entry in the asset account (e.g. checking account) and split the entry to an income account (e.g. patient income).

When do I need to create a manual deposit entry (DEP)?
When you receive income from a non-patient source (e.g. a vendor refund). Manually create a deposit entry in the asset account, split to an account that makes sense for the payment source.

What is the Reconcile button for?
This is only visible when viewing an asset account and is used to Reconcile transactions with bank account statements. A statement is reconciled when the Sum of Transactions and the Target Change equal in value. If they do not match, there is an incorrect or missing entry.

How do I use the Deposits feature in Open Dental with QuickBooks?
In Accounting Setup, select QuickBooks in the upper right under Deposit Software. Linking your QuickBooks file will allow the software to create deposit entries in QuickBooks accounting (checking account and income account). See QuickBooks for more information.

Accounting Transactions
In Accounting, double-click on an account from the Chart of Accounts.

From the Transaction History you can view, add, and edit accounting transactions.

Transactions already entered are listed by date. By default, the asset, liability, and equity accounts show the entire history. Expense and revenue accounts default to the current year. To edit a transaction, double-click an item.

Add Entry: Add a new transaction.
Reconcile: (asset accounts only) Reconcile monthly bank statements. See Reconcile.
Print: Print the list of transactions.
Filtering Options: If you change filter criteria, click Refresh to update the list.
  • From/To: View transactions for a specific date range. Click [V] to select dates from a calendar. Click [V] again to close the calendar.
  • Find Amt: Search the Debit and Credit columns for a specific amount.
  • Find Text: Search for specific text in the Chk # and Memo columns.
Export: Save the list of accounting transactions as a text or Excel file. Use the filtering options to limit the transactions that are exported.

Created by: The logged-in user that made the accounting transaction.

Last Edited by: The last user logged-in user that made changes to the accounting transaction.

Clear: X in the column indicates the entry has been reconciled.

**Add a Transaction**

Click Add Entry to add a new transaction. The Edit Transaction window will open.

By default, the Simple view of the transaction is shown. Every transaction is split between at least two accounts: the account the amount is deducted from (usually an asset account) and the account the amount is assigned to (often an expense account). To split a transaction between more than two accounts, uncheck the Simple box, then see Complex View below.

- **Date/Time Entered**: The date and time the transaction was added.
- **Date/Time Edited**: The date and time the transaction was edited.
- **User Entered**: The logged-in user that made the accounting transaction.
- **User Edited**: The last user logged-in user that made changes to the accounting transaction.
- **Date**: The date of the transaction. Transactions will be sorted by this date.
- **Amount**: The transaction amount. To deduct an amount from the account, enter a negative value.
- **Other Account**: Click Change to select the second account.
- **Memo**: Notes to identify this transaction. To enter a different memo for the Other Account, uncheck Simple.
- **Check Number**: Optional. Enter a value to represent the transaction for reference (e.g. check number, DEP for deposit transactions, AW for automatic withdrawal transactions, etc.)
- **Source Documents**: The source of deposit or patient payment. If Automatic Deposit Entries and Automatic Payment Entries are set up, deposits and patient payments will be automatically attached as a source document. Click Detach to remove the source document.
  - Deposit: The date and total amount of the attached Deposit Slip(516).
  - Payment: Patient Payments(158) can only be seen and detached from this window.

**Complex View**

Use the complex view to split a transaction to more than two accounts (e.g. for credit card payments) or to assign a different memo under each account. Transactions can be split however you wish but all debits must equal the sum of all the credits.
Reconcile Date: The date this transaction was reconciled. See Reconcile(559).
Add: Create a split to another account.
Totals: Total Debit and Credit amounts split between the accounts (must equal).
Memo Same For All: Uncheck to enter a different memo for each split.
Export: Save the Edit Transaction details to a text or Excel file.

To split a transaction to more than two accounts:
1. Uncheck Simple
2. (optional) Uncheck Memo Same for All to enter a different memo for each split.
3. Click Add to create a new split or double-click an existing split to edit.

4. Enter the split details and click Change to select the splitting account.
5. Click OK in the Edit Journal Entry window to save the split.
6. Repeat for each split.

**Reconcile**

Use the reconcile feature to ensure bank records match the accounting entries in the accounting system.

In **Accounting** (546), double-click an asset account. Click **Reconcile**.

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**Reconciling**

Once the bank statement is received, double-click on the corresponding asset account from the Chart of Accounts. The Reconciles window will open with a list of previous reconciles. Click **Add** to start a new reconcile. The Edit Reconcile window will open and list transactions not yet reconciled. To print the list of transactions, click **Print** or click **Export** to save the list as a text or Excel file.
Date: Change the date to match the bank statement date.

Starting/Ending Balance: Enter the bank starting and ending balances shown on the statement.

Target Change: This value is the difference between the starting and ending balance.

Compare the listed Transactions with the bank statement transactions. For every matching transaction, click in the X column to mark it as reconciled. To quickly find a transaction, enter a value in the Find Amount field. Transactions with the matching amount will highlight yellow.

Chk #: The check number for the corresponding accounting transaction. Typically, a withdrawal transaction (i.e. check payment to a vendor or refund check to a patient). Check payments received from insurance or patients are not entered as individual transactions but summed together as a deposit (DEP).

Date: The date the transaction was added to the Accounting system. This date may be slightly different than the date on the bank statement to account for mailing of check payments and deposit turn around times.

Deposits: The amount of the transaction if a deposit. If the transaction is not a deposit this field will be blank.

Withdrawals: The amount of the transaction if a withdrawal. If the transaction is not a withdrawal this field will be blank.

If voided checks are recorded as $0 accounting transactions, both the Deposits and Withdrawals fields will be blank for the given transaction date. Those can either be include on the reconcile or a separate reconcile may be saved just for those blank transactions.

The Sum of Transactions represents the reconciled items (those marked with an X). As transactions are reconciled this value will change. The goal is to match the Target Change value and the Sum of Transactions, when this is done the reconcile is complete. To prevent users from editing the transactions once the reconcile is complete, check Locked. The reconcile cannot be locked unless the Target Change value and the Sum of Transactions match.

Click OK to save and exit the reconcile. Only transactions with an X will be saved in each reconcile. These transaction will also be marked with an X in the clear column of the Transaction History(556) window.

Edit a Reconcile
To edit a locked reconcile, double-click into the reconcile and uncheck Locked. Make the needed changes, then lock the reconcile before clicking OK to save.

Accrual Accounting
Most small dental offices use cash basis Accounting(546) rather than accrual basis accounting. This page is an attempt to discuss how to use Open Dental in an accrual basis accounting scenario.

Current Guidelines
1. In Global Security Settings(1107), use the lock date feature to 'close out' each month.
2. After locking, run monthly reports. Never unlock to make historical changes.
3. PPO writeoffs: See ReportSetup - Misc Settings\(^{(1096)}\), where it discusses the option for "Default to using Proc Date for PPO writeoffs". Use method 2 (insurance payment date) to avoid changing history.

To keep track of prepayments, see Unearned / Prepayment\(^{(191)}\). Unearned Allocation Report\(^{(1326)}\)

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**Email Inbox**

In the Manage Module\(^{(487)}\), click Email Inbox.

In addition to regular email, this is also where you view WebMail\(^{(1672)}\) (only when the provider is logged in).

Emails received by the practice/clinic/group email address are viewable by all users (See Email Setup\(^{(747)}\)). User-specific emails are only viewable when the user is logged on (see Email Address Edit\(^{(599)}\)).

This window is non-modal, meaning it can be left open in the background while you access other areas.

**View Messages for address**: Lists all mail addresses the user can view messages for. Click the dropdown to select a different address.
- Defaults to the logged-on user's email address or the practice/clinic/group email address.
- WebMail is for Secure WebMail Feature and only is an option when the logged-on user is a provider.
Setup: Access Email Setup(747) for practice/clinic/group setup.

Inbox Columns
Inbox lists all messages received by the selected address. Click a column header to sort the messages alphabetically in ascending or descending order.

- **From**: The email address of the sender.
- **Subject**: The subject sent with the email.
- **Date Received**: The date and time the email was received by the mail server.
- **MessageType**: The type of message.
  - Regular email: A clear text email.
  - Encrypted email: An encrypted email.
  - SecureWebMail (sent via the patient portal)
  - Unsent
- **Sig**: Y Indicates the message is digitally signed (an encrypted email) and the sender is a trusted source. N indicates there is digital signature, but the sender is not a trusted source yet. Click the N to add a source to your trusted list.
- **Patient**: The patient attached to the email. If blank, there is no patient attached. Open Dental automatically attempts to attach a matching patient to incoming messages using this logic: When an encrypted email with an attached Summary of Care (ccd.xml), the program searches for a match using LastName, FirstName and Birthdate. Otherwise, the program searches for a matching patient based on email address.

Buttons

- **Refresh**: Download new emails. Only enabled when you are currently on the Computer Name Where New Email is Received. Downloaded emails are only copied from the mail server.
- **Compose**: Create a new email message.
- **Reply**: Create a reply message for the selected email.
- **Reply All**: Reply to all email addresses included in the email.
- **Forward**: Forward a message.
- **Change Pat**: Attach the message to a patient. Patients are automatically attached to incoming messages when Open Dental can find an exact match.
- **Mark Read/Mark Unread**: Change the message status. Bold messages indicate unread messages.

View Incoming Messages
New emails on the mail server are automatically synced in the background using the Open Dental Service(1415). Automatic download occurs every time Open Dental starts, when the inbox is opened, and at set intervals (see Email Setup(747)).

1. Under View Messages for address, select the address you want to view messages for.
2. Click the Inbox tab. Unread messages will be bold.
3. Highlight a message to preview the message text in the lower portion of the window, or double click a message to open it in a new window.

Patients are automatically attached to incoming message when Open Dental can find an exact match based on certain criteria. To select a patient to attach, click Change Pat.

Reply to a Message
Select the Inbox tab, then select the original message.

Click Reply or Reply All. The Email Message Edit(1656) window will open with the From and To addresses filled in, the original message text notated in the body text, and the cursor at the top of the text box.
Enter the reply message, then click **Send**.

A copy of the message will list under **Sent Messages**.

**Compose a New Message**

Click **Compose**.

On the **Email Message Edit**(1656) window, enter the message details (To, Subject, Body text, Attachments, etc.)

Send the message.

A copy of the message will list under Sent Messages.

**View Sent Messages**

Sent Messages lists all messages sent by the selected address from Open Dental. Sent messages can only be viewed, not edited. They can be deleted if there is no patient attached.

Click the **Sent Messages** tab.

Highlight a message to preview the message text in the lower portion of the window, or double click a message to open it in a new window.
Sent Messages columns: The columns are the same as the Inbox, except for the following:

- **Sent To**: The email address of the recipient.
- **Date Sent**: The date and time the email was sent by the mail server.
- **Msg Type**: The status of the message.
  - Sent: A clear text email message was sent.
  - SentDirect: An encrypted email was sent.

**Search for Email Messages**
To search for specific emails by attached patient, email address, date range, or subject/body text, use the Search area.

Select the Inbox or Sent Messages tab.

Enter the search criteria:
- **Patient**: Click [...] to select a patient.
- **Email Address**: Enter the email address.
- **Date From/To**: Search for messages sent or received during a date range. Use the DD/MM/YYYY format.
- **Subject/Body**: Search for specific in the subject and body text. Only include messages with attachments: Check to only list messages that have an attachment. Uncheck to ignore this criteria.

Click **Search** to enter search mode (turns yellow). Matching results will list.
Click Clear to exit search mode.

Show Email In
In the Show Email In area, select where an individual email will show or not show. To show the email in an area, highlight it. To hide the email in the area, deselect it. By default, all areas are selected.

- Email Inbox
- Appointment Edit: Edit Appointment (20), Communications Log area
- Chart Progress Notes: Chart Module (298), Progress Notes
- Account Progress Notes: Account Module (150), Progress Notes
- Account Comm Log: Account module, Communications Log area

Show Hidden Emails: Check this box to show emails that have been hidden in all areas.

Delete Messages
Deleting a received message removes it from the inbox only, not the email server. It will not download from the email server again. Sent messages can only be deleted when there is no attached patient.
1. Highlight the message.
2. Click Delete.

Emails attached to a patient are removed from the inbox, yet still visible in the Commlog and Progress Notes.

Emails not attached to a patient are permanently removed.

Encrypted Emails
To send and receive encrypted email, both parties must have established trust by sharing public key security certificates.

When a received email is encrypted, decryption is automatically attempted.
- When successful, the Sig column will show Y (indicating the sender is a trusted source) and the message text will be readable.
- If unsuccessful, a N will show instead to indicate the sender is not yet a trusted source, and the message will not be decrypted.

Why Decryption Fails: Decryption can fail if encrypted email is not set up on the workstation (email security certificates are not installed), if there are permission issues, or when the sender is not listed as a trusted source on the workstation (sender's public certificate has not been installed on the workstation). If permission issues are the cause, try running Open Dental as an administrator.

To add a sender as a trusted source:
Click the 'N'.
Click Trust.

Retry Decryption: When decryption has failed, a Decrypt button shows on the left of the Edit Email Message window:

Click Decrypt to attempt decryption again (e.g. on a different computer, once encrypted email is setup, or once the sender is a trusted source). If the message is from an unknown recipient that is not in your trusted list, you will be prompted to add the recipient to your trusted list.

If you choose OK, Open Dental will attempt to locate the public certificate for the sender and, if found, add it before attempting decryption again.

See also Email Encryption Options(1662)

Troubleshooting
See Email Errors(1667).

If using Gmail, all messages will be downloaded, except for spam, trash, and chats. This is a POP3 issue. See https://support.google.com/mail/answer/16418?hl=en. This issue would be fixed by using IMAP protocol instead (feature request #3276)
Email Inbox Encryption

Encrypted emails can be viewed in the Email Inbox(561).

Note: For both standard encrypted email and Direct messaging, both parties must have established trust by sharing public key security certificates. See Email Encryption Options(1662) for details.

Open the Email Inbox. In the Manage Module(487), click Email Inbox, or on the EHR Summaries of Care(445) window click Email in the Receive by area.

If the email is an encrypted message, decryption is automatically attempted.
- If decryption is successful, the Send/Received status is ReceivedDirect. The Sig column will indicate a Y.
- If decryption fails, the Send/Received status is ReceivedEncrypted. See When Decryption Fails below.

Verify the patient. If a Summary of Care file is attached, Open Dental will attempt to automatically match the patient with an entry in the database based on matching email address.
- If an exact match is found, the email is attached and the patient name shows in the Patient column.
- If an exact match is not found, then no attachment is made, and the Patient column will be blank.

Click Change Pat to select a Patient.

Open the Message: Double click on the message. It will open in the Edit Email Message window in view only mode. Attachments will list in the upper right. Double click an attachment to open.

When Decryption Fails

Automatic decryption can fail if Direct messaging is not set up on your computer, or if the sender is not listed as a trusted source on the workstation.

Add Sender as a Trusted Source: N lists in the Sig column for a message when the sender is not a trusted source. To add the sender to your trusted list, click the N.
Click Trust to add the sender.

Retry Decryption: If decryption has failed, a Decrypt button will show on the left of the Edit Email Message window:

Previous attempts to decrypt this message have failed. Decryption usually fails when your private decryption key is not installed on the local computer. Use the Decrypt button to try again.

Click Decrypt to attempt decryption again (e.g. on a different computer, once Direct messaging is setup, or once the sender is a trusted source). If the message is from unknown recipient that is not in your trusted list, you will be prompted to add the recipient to your trusted list.

If you choose OK, Open Dental will attempt to locate the public certificate for the sender and, if found, add it before attempting decryption again.

**ERAs**

ERA 835, also known as electronic remittance advice format, is an electronic explanation of benefits (EOB) that can be automatically downloaded.
In the Manage Module(487), click ERAs.

Automatically or manually download ERAs then use the ERAs to auto-populate insurance paid amounts by claim and quickly receive claims and finalize insurance payments.

Webinar: ERA 835

Set up Requirements
To start using, sign up for ERAs with a clearinghouse. Automatic download of ERAs are supported through ClaimConnect E-Claims(656), Denti-Cal(660), Change Healthcare Medical/Emdeon Medical(667), and Electronic Dental Services(666). Not all insurance carriers or clearinghouses offer ERAs, or the ability to automatically download. If automatic downloads are not available, manually download ERAs to the Claim Report Path in the Clearinghouse(645) set up.

Note: User must have permission for Insurance Payment Create to access ERAs.

ERA Troubleshooting(577)

Managing ERAs
ERAs can also be viewed and processed via the Insurance Claims window, History grid. See Send Claims(489). By default, ERAs received in the last 7 days that have a status of unprocessed, partial, or not finalized will list. Claims will be matched with an ERA and if one is not found, you will be prompted to find the correct claim (see, ERA Match with Claim(576)). If more than one patient is associated with an ERA, the number of claims on the ERA shows in the Patient Name column instead of a name. Double-click on a claim to Process(570) and view EOB Claim Details(573).

If a claim on the ERA list has special circumstances, add the claim to the Outstanding Insurance Claims Report(1315) and set a tracking status. See, Track ERA(572).

Use the filter options to change the ERAs listed in the ERAs grid. Click refresh after each change.
From/To: Change the date range. Click the down arrow to select dates from a calendar then click the up arrow to collapse the calendar. Click the W buttons to jump back or forward one week.
Amount Range: Only show ERAs within a certain payment amount range. Min = the minimum payment amount to show. Max = the maximum payment amount to show. Leave blank to show all ERAs regardless of payment amount.
Control ID: Filter by Control ID. Option must be enabled in Show Features(806).
Carrier: Filter by carrier.
Check# or EFT Trace#: Only show ERAs for a specific check number or EFT trace number.
Clinic: Filter by clinic. If an ERA has more than one clinic, multiple will list in grid.
Status: Filter by ERA processing status.
  - Unprocessed: ERAs that have not been processed at all (no claims are received).
  - Partial: ERAs with some claims that are received, and others that are not.
  - Not Finalized: ERAs with claims that are received, but still need to be finalized.
  - Finalized: ERAs with a finalized payment.
Code types are used to determine payment methods. The following codes are used:

- **ACH**: Automatic clearinghouse (Direct Deposit)
- **CHK**: Paper check
- **NON**: No payment issued
- **FWT**: Federal wire transfer

**ERA**

In the [ERAs](568) window, double-click on an ERA.

See [Process ERA](575) for details on receiving the claim and finalizing the payment.

Double-click on a row. Any claims that were split by the payer will be matched and processed together.

All claims in the ERA list under Claims Paid. Right click a claim and select *Go to Account* to view patient’s account information.

**Raw Message**: The electronic file sent by insurance. This is used for troubleshooting purposes. See [ERA Raw Message](575).

**Provider Adjustments**: Double-click a row to open a simple window that can be used to copy text.
**Detach Claim**: When a claim cannot be processed in the ERA window, or, after processing the Claim an X is still not showing in the *Recd* column, follow the steps below:

1. Highlight the problem claim and click **Detach Claim**. *N/A* will appear in the *Recd* column to indicate it has been detached from the ERA.

2. Right click on the detached claim and select **Go to Account**.

**Note**: If the patient is not found due to a name mismatch or other error, make note of the *Date Service* and *Status*, then *Select Patient* (1649) manually.

3. If not previously entered, add payment details on the claim using the standard **Receive Claim** (229) process.

4. Repeat steps 1-3 above as needed for any other claims that need to be detached from an ERA. After all the claims on an ERA are Received with an *X* or detached with an *N/A*, proceed to the next step to finalize the payment outside of the ERA window.

5. To finalize payment for an ERA with a detached claim, double-click on any claim in the Account module. Click Batch and follow the normal **Finalize Insurance Payment** (231) process. Once all claim payments have been processed or detached, the status of the ERA will change to *Finalized*.*. The asterix (*) identifies ERAs with detached claims.

**Find Claim Matches For Detached**: Click to find claim matches for any detached claim (claims with a received status of *N/A*).

**EOB Claim Details**: Highlight a claim and select to view a breakdown of the claim. See **EOB Claim Details** (573).

**Print**: See **Print ERA** (571).

**Delete**: Delete this ERA. All claims must be manually detached.

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**Print ERA**

In an **ERA** (570), click **Print** or **Print Preview**.
The default for a printed ERA is shown above.

To customize the ERA, see ERA Layout(1159).

To customize the ERA header, see ERA Grid Header Layout(1160).

**Track ERA**

In an ERA(570), in the Claims Paid grid, right click a problem claim. Select Add Tracking Status.
If a claim on ERAs has special circumstances, you can add the claim to the Outstanding Insurance Claims Report with a custom tracking status and error code.

Note: If a matching claim is not found, you will be asked to manually locate it. See ERA Match with Claim.

Select the Custom Track Status. Customize status options in Definitions: Claim Custom Tracking.


Add any related notes.

Click Update.

The claim will now appear on the Outstanding Insurance Claims report and will be detached from the ERA.

**EOB Claim Details**

In an ERA, at the bottom left, click EOB Claim Details.
Alternatively, double-click on an unreceived claim. Click **EOB Claim Details** in the *Verify and Enter Payment* window.

Double click the Claim Adjustments, Claim Adjudication Info, or Supplemental Info grid to open a simple window that can be used to copy message text.

To print, see **Print ERA**(571).

To view details about procedures, double click a row in the Procedure Breakdown grid.
Double click a grid to open a simple window that can be used to copy text.

Click **Print** to print a copy of the procedure information.

**ERA Raw Message**

In an **ERA**(570), at the upper right, click the **Raw Message** button.
In an ERA (570), in the Claims Paid grid, double-click on an EOB. If a matching claim is not found, this window will come up.

The raw message text for ERA (568) messages is viewable by clicking Raw Message on the Electronic Remittance Advice window.

Click Copy All to copy all text.

Click Print to print the raw message to the default printer.

Click OK to close the window.
If Open Dental can't automatically find matching claims for an ERA, then you will be prompted to find the correct claim.

When attempting to automatically match ERAs with a claim, Open Dental looks for this criteria:

- Claims with a matching date of service and claim fee.
- Claims with one or more of the following:
  - Claims with a matching claim identifier (it must be an exact match or partially match at least the first 15 characters of the ERA Claim Identifier).
  - Claims with a matching patient first name and last name (not case sensitive), with an exact subscriber ID match or partial match of all but the last 1 or 2 characters.

Claim identifiers are viewable on the Edit Claim - Misc Tab.

Click Find to search for a patient.

Use the filter criteria to narrow down the search results.

- Date From/To: The date of service on a claim.
- Claim Fee: The total fee on a claim.

Click Refresh to filter results, then select the correct claim from the list.

The Procedure Matching Details will show a list of procedures on the selected claim. If they match the ERA, they will show in green. If they do match the ERA, they will show in red.

Once the correct claim is selected, click OK to continue processing the ERA.

ERA Troubleshooting

The information provided below is for ERAs troubleshooting.

Note: The first step in any troubleshooting is to update to the latest stable version of Open Dental.
After entering payments, patient accounts show a credit.
The plan type is not set to PPO Percentage. An in-network insurance plan must be set to PPO Percentage for write-offs to calculate correctly. See PPO Insurance Plan(114) If using an out-of-network plan (category percentage) you may need to manually zero out write-offs on procedures.

How do I manually download reports?

1. Contact your clearinghouse to obtain ERA files. The files must be in the specified 835 format to work.
   Note: If using ClaimConnect, log into your ClaimConnect account and select Reports, then ERAs. Click the download button next to a claim then save the ERA to the report path.

2. Verify the report path set in your Clearinghouses(645).
3. Copy and paste reports to the designated report path. Or download reports directly into path.
4. In Open Dental, go to the Manage Module, Send Claims. This will automatically retrieve the downloaded reports.

I have a duplicate ERA.

Double-click the duplicate ERA, then click Delete.

When clicking Send Claims, receive error: Error retrieving. Era request unsuccessful. Error message received directly from ClaimConnect: 150. Service Not Contracted.
This means you are not signed up for the ERA download service with ClaimConnect(656). You have two options:
- To enable the service, contact ClaimConnect.
- To stop the error message (and not enable the service), update to version 16.1.14 or greater.

ClaimConnect Note: Once ERAs are downloaded they are marked processed on the ClaimConnect website. To mark an ERA as unprocessed (e.g. if there is an error), do so on the ClaimConnect website.

Insurance sent back different code than what was billed (e.g. FMX instead of Pano/BW).
Open Dental will post payment as total. You can leave this as is, or split payment between completed procedures.

Logic: Sometimes EOBs do not itemize payments by procedure. In these cases, paid amounts are assigned to the Total Payment amount. If procedure payments are known (itemized), then those payments will be subtracted from the Total Payment amount, and amounts are indicated in each procedure row. When all procedures are itemized, and there are no claim adjustments, there will be no Total Payment entry because it is unnecessary.

Why won't some of my ERAs download?
Common reasons certain ERAs won't download:
- The ERA was viewed on the clearinghouse's website prior to it being downloaded in Open Dental. Viewing the ERA on the clearinghouse's website will flag the ERA as processed and not available for download.
- The ERA was not downloaded into Open Dental with in the clearinghouse time limit. This is typically 7 days. If you need Open Dental to be able to download ERAs from a specific date range, contact your clearinghouse and request they make that date range available for download again. If you are set up for automatic downloads of ERAs, check your Clearinghouse Settings(645) to make sure it is working.

I need to get ERA's for a carrier that is not contracted with a clearinghouse that provides ERAs in the standard 835 format to be used by my Open Dental program. What can I do?
If the payer can provide you with the ERA file (835) it can be manually downloaded into the clearinghouse report path, then processed as usual. If not, you must use paper or other way of getting the EOB. Currently Claimconnect, Electronic Dental Services (EDS) and Dentical are able to provide ERA 835s to you. Keep in mind that most processors are not willing to do 835s only, they also want you to file all of your claims with them to provide this service.
What if the carrier is contracted with Emdeon though, isn't Emdeon a large clearinghouse that should be able to provide 835s?
Emdeon/Change Healthcare may be able to provide 835's in the future, Open Dental has asked and not gotten useful responses.

**Import Ins Plan 834**
In the **Manage Module** (487), click Import Ins Plans.

![Import Ins Plan 834](image)

The Import Ins Plan 834 feature is only available when **Public Health** (71) is turned on. It is a very specific function that imports data in 834 format. 834 files are Benefit Enrollment and Maintenance files that contain patient and insurance plan information. Importing a file can update patient information if a matching record already exists and create patient records if they don't.
- Only X12 files in 834 format can be imported.
- One file is imported at a time.
- Import oldest files first to preserve the order of insurance plan changes.

Under Import Path, click [...] to select the folder where the 834 file exists. All files that exist in the folder will list. The oldest file will be highlighted yellow and processed first.
Note: If you don’t see the file you want, click Refresh.

Click OK to open the oldest file (highlighted yellow). A list of all patients in the file will open. If Open Dental is able to automatically match a patient to an existing patient record (based on last name, first name, birthdate) the PatNum field will include the patient's Open Dental number.
To manually attach a patient to an existing record, double-click the patient row, then select the patient.

**Automatically create new patients when importing plans for unknown patients...**:
- Checked: When you click OK, any patients who don’t already match an existing patient in Open Dental will have a new record created.
- Unchecked: Only patients with a matching patient record (PatNum) will be updated. Unmatched patients will be ignored.

**Drop all existing patient plan when importing new plans**:
- Checked: For patients already in the database, their current insurance will be dropped and the insurance plan being imported from the 834 will be added.
- Unchecked: For patients with existing plans, if the plan being imported differs, it will be added as secondary insurance.

Note: You cannot choose specific records to import.

Click OK to begin importing patients and insurance information. A confirmation window will open.

Click OK again to begin. Depending on the size of the file, it may take some time. A progress indicator will update status of the import. Minimizing the screen may reduce import time.

When the import is complete, a window will open listing the changes that were made.
To print the list, click Print. Click OK to close.

In the MainMenu, click Lists, Insurance Plans and verify the plans imported correctly. See Insurance Plans.

- Note: As files are processed, they will be moved to an Archive folder within the original folder. If a file is partially processed for some reason, the processed portion will move to the archive folder, while the unprocessed portion will remain in the original file.
- Several processes that occur during import of the 834 are tracked in the Audit Trail.

## Messaging

Internal messaging can be used to send messages to any, or all, workstations in an office.

In the Manage Module, at the bottom, is the Messaging area.

Messages can include text, sound and/or light. They can be To and From specific users, but everyone will see or hear it. For example, a message can be sent to all computers that says Doctor, Spouse, Line 1. Or a message could be sent that says Doctor, Op 1 with an accompanying message button that lights up.

### Related Links:
- Webinar: Messaging and Messaging Buttons
- To trigger buttons to light up with messaging, see Messaging Buttons.
- Use Tasks Area for a more direct way of sending messages to specific staff members.
- Use Integrated Texting Feature for text messaging to patients

The four columns (To, From, Extra, Message and Send) list the Message Element that are already set up. Several messaging elements come preset in Open Dental, but you can customize or add new ones.

### Send an Internal Message

1. Click on a To, From, and/or Extra Item.
2. Click an item in Message (& Send) to immediately send it.

For example: Doctor | Front | Spouse | Line 1 will send and speak Doctor, Spouse, Line 1.

### Send an Internal Custom Message

1. Type the message in the Message field.
2. Click on a To, From, and/or Extra Item.
3. Click an item in Message (&amp; Send) to immediately send it, or click **Send Message** to send without including a Message item.

For example: pharmacy verifying prescription | Doctor | Front | Urgent | Line 1 will send and speak **Doctor, Urgent, Line 1** and pharmacy verifying prescription will show in the Messaging History text.

### Acknowledge Messages
All sent messages show in the Message History until they are acknowledged. By default, all users are shown in the list. Filter messages using the To User dropdown.

Eventually every message should be acknowledged. Click on the message, then click Ack. Acknowledged messages older than two days are deleted from the database once per week. To select multiple messages, press the Ctrl key while clicking on the messages.

If the message triggered a messaging button, you can also click on the lit button to acknowledge it. Ack’d messages do not usually appear in the list since nobody needs to see them. To see acknowledged messages, check the Include Acknowledged box.

**Include Acknowledged**: Check to view messages that have been acknowledged. A field labeled **Days** will appear. Enter the number of days for which you want to see acknowledged messages. For example, enter 1 in the Days field to see acknowledged messages only for the last one day. You can go back a maximum number of 10 days.

**Include Acknowledged**

Include Acknowledged  
Days 1

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### Time Clock
In the **Manage Module** (487), at the upper-right, is the Time Clock area.

![Time Clock](image)

Employees can use the time clock to clock in and out of work.

Before using the time clock, the following tasks must be completed.
1. Add employees. See **Employees** (1233).
2. Create user profiles for each employee. See **User Edit** (1109).

See also **Webinar: Time Cards**.

By default, the time displayed is the time of the server (the computer running the MySQL program). To use a workstation's local time instead, see **Miscellaneous Setup** (921).
Clock in: Click an employee, then Clock In.

Clock out: Click an employee, select a status (Home, Lunch, Break), then click Clock Out For.

- **Home**: Use this status when leaving for the day. The clock out time will be recorded on the time card.
- **Lunch**: Use this status when clocking out for an unpaid break. The clock out time will be recorded on the time card. Note: Lunch is hidden when *Allow paid 30 minute breaks* is unchecked in Manage Module Preferences (744). Use the Break status to clock out for unpaid breaks instead.
- **Break**: The behavior of this status is determined by the Manage Module Preference, *Allow paid 30 minute breaks*.
  - If paid breaks are allowed, use this status to clock out for paid breaks. The length of the break is tracked in the time card under Breaks. To determine if break time that exceeds 30 minutes is considered paid versus unpaid, change the setting in Time Card Setup for *Calc Daily button makes adjustments if breaks over 30 minutes*.
  - If paid breaks are not allowed, use this status to clock out for unpaid breaks. The clock out time will be recorded on the time card.

If an employee edits a time card so the clock out event happens in the future, the status will show as **Manual Entry**.

A clock event row will be created in the time card each time you clock in. If a pay period doesn't exist, attempts to clock in will trigger an alert.

When using clinics, the clinic selected in the main menu determines which employees are listed. When clocking in, this clinic is associated to the clock in event and subsequent clock out events.

Other options:
- **Manage**: Calculate pay period totals and perform other time card management tasks. See Manage Time Cards (583).
- **View Time Card**: View or make corrections to the selected employee’s time card.
- **View Breaks**: View or make corrections to breaks for the selected employee. This button is disabled when *Allow paid 30 minute breaks* is unchecked (off) in Manage Module Preferences.
- **View Schedule**: Quickly view the selected employee(s) schedule. Schedule View Employee (590).
- To create rules for overtime or differential hours, see Time Card Setup (773).

**Troubleshooting**

**Employee doesn't list in the time clock.**
Make sure the employee is added to the Employee List and not marked hidden.

**Clock events are not displaying on time cards.**
In Time Card Setup, check that a pay period is set up for the current date. Clock events only show if a pay period exists for today.

**Employee is listed, but can't clock in.**
Associate the employee to a user in Security.

**Manage Time Cards**
In the Time Clock (582), click Manage to view all employee time cards at once.
Time card management is only available to users with the Edit All Timecards security permission. Calculations correspond with ADP format requirements for offices that use ADP for payroll.

**Related links**
- [Time Card Setup](#)
- Webinar: [Time Cards](#)

**Setup:** Access [Time Card Setup](#).

**Reports:** Run payroll reports.
- Print Grid: Print the Employee Time Cards grid.
- Export Grid: Export the grid data as a txt file to a location on your computer. When the export is complete, a message will show indicating the file name.
- Export ADP: Export the time card data in ADP format (csv file) to a location on your computer. If any errors are detected, you will receive a notification. When the export is complete, a message will show indicating the file name. To include the employee name when exporting, see Manage Module Preference, ADP export includes employee name.

**Pay Period:** Click the right/left arrows to move back or forward a pay period. The Start, End, and Paycheck dates will automatically change to reflect the pay period.

**Clinic:** If using Clinics, select the clinic to manage time cards for. The logged-on user can only manage time cards for clinics they have access to. The default is determined by the clinic selected in the main menu, Clinics. All employees who have clock events for the selected clinic will list.

**Employee Time Cards grid:** Each row represents an employee's time card for the pay period. Employees are listed in alphabetical order by last name. Only employees who have at least one clock in/out event during the pay period will list. Adjustments alone do not cause an employee's time card to show.
- Total Hrs: Total number of hours worked (regular, overtime, and differential).
- Rate 1: The number of regular hours worked.
- Rate 1 OT: The number of regular overtime hours worked.
- Rate 2: The number of regular differential hours worked.
- Rate 2 OT: The number of overtime differential hours worked.
- Rate 3 PTO: The number of hours for paid time off added as an adjustment with a PTO Type selected.
- Notes: The notes showing for each employee comes from the pay period note on the individual's time card.

**Clear Manual Adjusts:** Clear any manually entered adjustments made to a clock event for selected employees.

**Daily:** Calculate total hours worked each day for all employees, taking into account rules for overtime, differential hours,
and your preference for breaks over 30 minutes. Adjustments will be made within a clock event; new rows will not be created.

Note: When running Daily Calculations the current day will be excluded if it falls within the pay period being calculated.

**Weekly:** Calculate overtime for all employees (more than 40 hours in a week).

Note: Take note of any clock event notes and any errors that need to be fixed before running calculations.

**Print All:** Print all time cards at once. Only the first two lines of a note will print (approximately 190 characters).

**Print Selected:** Only print time cards for selected employees. Press Ctrl + click to select multiple employees. Only the first two lines of a note will print (approximately 190 characters).

**Other Time Card Options**
- **Time Card Security Options:** Security(1106).
  - Time Card Security Enabled: Makes the checkbox for Users cannot edit their own time card active.
  - Users cannot edit their own time card: If checked, individual users cannot make changes to their own time card. Most offices keep this box unchecked, because it is useful when employees can make notes and fix errors. Error fixing is tracked well in time cards. This setting overrides the permission Edit All Time Cards.
  - Edit All Time Cards: Users with this permission can access the Time Card Manage window and edit everyone's time card. Normally only the office manager or administrator will have this permission.
  - Time Card Delete Entry: Users with this permission can delete time card entries.

**Time Card Calculations Options:**
- Create pay periods and rules for overtime, differential pay, allowed clock in times (Time Card Setup).
- Manage Module Preferences, Allow paid 30 minute breaks: Determines whether breaks that exceed 30 minutes are calculated as paid or unpaid.
- Manage Module Preferences: Set the first day of the week used to calculate weekly overtime (over 40 hours). The default is Sunday.

**Time Format Options:** In Time Card Setup, select the format for time (decimal or colon format), and whether colon format shows seconds.

**Add Adjustments to a Time Card**
Manually enter adjustments to account for holiday hours, additional overtime, etc. These adjustments create a separate row in the time card.

1. On the Manage Time Card window, double-click on an employee to open their time card.
2. Click Add Adjustments.
3. Select **Manually entered** to indicate this adjustment was entered manually and protects this adjustment from being deleted from auto deletion.

4. **Date/Time Entry**: Verify the date and time the adjustment is being entered. Defaults to today's date and the current time. Date/time determines the sort order of the adjustment on the time card.

5. **Hours**: Enter the number of hours to add to the time card. If removing hours, enter a negative number.

6. **Overtime Adjustment**: Check this box when this is an adjustment to account for overtime. Calculations totals will deduct the entered hours from regular time and transfer to overtime. Cannot be checked if a PTO Type has been selected below.

7. **PTO Type**: Select a PTO Adjustment Type if it applies to this adjustment. Add PTO types from **FILE NOT FOUND**.

8. **Note**: Enter any notes about the adjustment.

9. Click OK to save.

**Calculate Daily and Weekly Totals**

At the end of each pay period, calculate regular and overtime hours. Calculations can be run for all employees at once or per time card.

1. Check employee time cards for errors (e.g. no missing clock-in/out events). Add any manual adjustments. Correct any time card errors. See **Time Card Edit**.

2. Calculate total hours worked each day, taking into account rules for overtime, differential hours, and your preference for breaks over 30 minutes. Adjustments will be made within a clock event; new rows will not be created.
   - To calculate for all employees, click Daily.
   - To calculate for a single employee, click Calc Daily on their time card. If you don't like the results, edit the rules in Time Card Setup and run it again. Overrides can be made to individual clock events.

3. Calculate weekly overtime for employees who worked more than 40 hours in a week.
   - To calculate for all employees, click Weekly.
   - To calculate for a single employee, click Calc Weekly OT on their time card. If the total hours for an employee in a week is over 40, an additional adjustment row will be added for overtime hours. The weekly calculation will cross pay periods.

If using clinics, total hours and overtime hours are assigned by clinic.

**Hour Calculation Logic**
The math behind time card hour calculations is explained below.

Total hours = all hours worked (includes regular, overtime and differential (Rate 2) hours.

OT hours = overtime hours
Rate 1 hours = hours paid at the regular rate
Rate 2 hours = hours paid at the differential rate
Rate 1 hours = (1 - Rate 2/Total hours) * Regular hours
Rate 2 hours = (1 - Rate 2/Total hours) - Rate 1 hours
So Rate 2 hours + Rate 1 hours = Regular hours
Rate 1 OT hours = (1 - Rate 2/Total hours) * OT hours
Rate 2 OT Hours = (1 - Rate 2/Total hours) - (Rate 1 + Rate 2 + Rate 1 OT hours)

**TimeCard**

In the **Time Clock** area, select an employee. Click **View Time Card** or **View Breaks**.


All users can view their time card and breaks. If users are allowed to edit their time cards they can also edit clock events.

The Pay Period dates are shown at the top. Clock events in the pay period are listed in the grid.
- If a clock event has been altered, it is flagged in red text.
- If time card clock events are missing or not showing, this can be a clue to add more pay periods.
- **Pay Period right/left arrows**: Move back or forward one pay period.
- **Note**: A note specific to the payperiod as a whole.
- **Time Card** or **Breaks** radio button: Switch between full time card view and breaks only view. The Breaks radio button is disabled when **Allow 30 minutes of paid break** is unchecked (off) in **Manage Module Preferences**.

**Time Card Grid Columns**
- **In/Out**: The time the employee clocked in and out. Seconds are included in the math.
- **Total**: The total number of hours worked for that day.
- **Adjust**: Excess time is subtracted from the time card when breaks exceed 30 minutes and **Calc Daily button makes adjustments if breaks over 30 minutes** is checked in Time Card Setup.
- **Rate 2**: Hours worked that qualify as differential hours. Set up differential hours in **Time Card Setup** under Time Card Rules.
- **PTO**: The paid time off hours added as an adjustment with a PTO type selected. See **Manage Time Cards**.
- **OT**: The total overtime values of clock events may not match the total weekly overtime at the bottom because when the Admin user calculates weekly overtime, the values are not rounded up until the end. The bottom value is more accurate. Overtime number accounts for seconds but rounds to the nearest hundredth.
- **Day**: Hours worked that day in decimal format.
• **Week**: Total hours worked for the week in decimal format. Hours will show in the weekly column at the start of every day, until the end of the scheduled week.
• **Clinic**: The abbreviation of the selected Clinic (Clinic(1505)) in the main menu when the employee clocked-in.
• **Note**: Enter a note for a clock event, usually when an employee must change the time or type of the clock event.

For users with the *Edit All Time Cards* permission (See Manage Time Cards(583)):
• Employee right/left arrows: Scroll to the previous or next employee’s time card.
• **Add Adjustments**: Add adjustments rows to the grid for holidays, overtime, etc.
• **Calc Daily**: Calculate daily totals for this employee only. The employee must be clocked out for the day.
• **Calc Week OT**: Calculate weekly overtime (over 40 hours) for this employee only. The employee must be clocked out for the day.

**How Time is Calculated**

Regular Time: The left column shows total time worked rounded to the nearest minute in hours: minutes (colon) format. The right column shows times rounded to the nearest hundredth of an hour in decimal format. See Time Card Setup(773) for the difference between colon and decimal format. Regular time accounts for seconds in the entire pay period, but seconds are rounded up before the time is displayed.

- Colon or decimal format is determined by a setting in Time Card Setup. When using decimal format, the time card will round to the nearest hundredth. It will not show any thousandths even though they are present.

- Seconds are shown or hidden depending on the setting in Time Card Setup.

Overtime and Rate 2: The left column shows times rounded to the nearest minute; the right column shows times rounded to the nearest hundredth of an hour.

**Note**: Time totals (at the bottom) do account for seconds in the entire pay period, but seconds are rounded before they are displayed.

Breaks: See Time Clock(582), Clock out section for how breaks are calculated.

**Edit a Clock Event**
1. Double-click a column in the Time Card grid.
2. Edit the Clock In Date or Time, Clock Out Date and Time, or Out Status as needed. Only the Displayed fields can be edited.

3. (optional) Enter a note to describe the reason for the change.

4. Click OK to save.

Time Spans
- **Clocked Time**: Calculated automatically using clock in and clock out times.
- **Adj**: Added automatically when daily totals are calculated at the end of the pay period. If the option to make adjustments for breaks over 30 minutes is selected in Time Card Setup, a negative adjustment is made when an employee exceeds the allowed 30 minute break time on a given day. An override can be manually entered.
- **Overtime**: If there is an overtime rule for daily hours (e.g. overtime after 8 hours), and an employee meets the criteria, a value is entered. Hours will then be transferred from regular time to overtime in calculation totals. An override can be manually entered.
- **Regular time**: The total hours, plus or minus adjustments and over time.

Rate 2: Used to determine differential hours based on time card rules.
- **Total Time**: Clocked Time + adjustments.
- **Rate 2 Time**: How many of the total hours are Rate 2 hours (differential hours). You can enter an override manually.
- **Rate 1 Time**: Total Time - Rate 2 Time. Adjusts automatically based on the override amount.

To delete a clock event, users must have the *Time Card Delete Entry* permission.

**Common Mistakes and How to Fix Them**

Forgot to clock out when leaving for the day
1. When you realize the mistake the next morning, clock out (the Clock Out time will be wrong).
2. Immediately clock back in to begin today's time.
3. Double-click on the inaccurate clock event.
4. Correct the Clock Out date and the time. The status will remain home.

Clocked out for lunch and then never came back to work.
1. The next morning, clock in as usual.
2. Double-click on the clock out event for the previous day's lunch.
3. Change the status from Lunch to Home.

When clocking out for break, you discover that someone else accidentally clocked out using your time card. Your time card shows you have been on break for two hours and time is still ticking.
Option 1: Delete the clock event (double click on it, then click Delete). Only users with the Time Card Delete Entry permission are allowed to do this.

Option 2: When you are ready to clock back in, do so. Then, double click on the first inaccurate clock event and change the Clock In time so that it shows correctly.

Schedule View Employee
In the Time Clock area, select the employee(s). Click View Schedule.
Employee schedules can be quickly viewed and printed from the Manage Module (487).

The view will default to the current week’s schedule plus four weeks.

For most users, the view is read-only. The options available to these users are described below. Users with the Schedules - Practice and Provider security permission will access a view that allows them to edit schedules as well. See Schedule Setup (1099).

Filter Options: If you change a filter criteria, click Refresh to update.

- **From Date** and **To Date**: Customize the date range.
- **Show Practice Holidays and Notes**: Show practice notes and holidays.
- **Show Clinic Holidays and Notes**: Only an option when clinics is turned on. Show the selected clinic’s holidays and notes entered.
- **Clinic**: Only an option when clinics is turned on. Filter the view by clinic.
- **Show Schedule Filtered by Clinic**: Only an option when Clinics is turned on. Check the box to quickly select all providers and employees associated with the selected clinic and view their scheduled time blocks. While in this view, all buttons in the lower left are disabled and schedules can’t be edited.
- **Provider**: Select the provider schedules to view.
- **Employees**: Select the employee schedules to view.
- **Show weekends**: Show Sunday and Saturday schedules.
- **Print**: Print the schedule.
Main Menu

The Main Menu runs across the top of the main window and is always visible.

Each menu item has submenu items. You must click onto a menu item because Window F10 functionality is disabled in Open Dental.

Log Off:
Log the current user off of Open Dental. See Security(1106) to set up user groups, users, passwords, and permissions.

File

User Password(598), User Email Address(599), User Settings(1121), Printers(601), Graphics(603), Choose Database(605). Exit closes Open Dental.

Setup

Most setup options require the Setup Permission to access. Some submenu items are divided into categories.
Appointments: Appt Preferences(608), Appointment FieldDefs(614), Appointment Rules(617), Appointment Types(619), Appointment Views(7), ASAP List(47), Confirmations(612), Insurance Verification(627), Operatories(628), Reactivation(631), Recall(140), Recall Types(635).
**Family/Insurance:** [Family Preferences](#), [Claim Forms](#), Clearinghouses, Insurance Categories, Insurance Filing Codes, Patient Field Defs, Payer IDs.

**Account:** [Account Preferences](#)

**Treat'Plan:** [Treat'Plan Preferences](#)

**Chart:** [Chart Preferences](#), EHR, Procedure Buttons

**Images:** [Image Preferences](#), Imaging Quality

**Manage:** [Manage Preferences](#), E-mail, Messaging, Messaging Buttons, Time Cards

**Advanced Setup:** Computers, Generic HL7, FHIR, Replication, Show Features.
Security Setup: Security Settings(1106), Add User(1109).

Others: Alert Categories(1635), Auto Codes(813), Automation(819), Auto Notes(317), Data Paths(824), Definitions(835), Dental Schools(808), Display Fields(900), Enterprise(904), Fee Schedules(914), Laboratories(918), Miscellaneous(921), Module Preferences(927), Ortho(927), Practice(931), Program Links(934), Quick Paste Notes(1088), Reports(1276), Requirements Needed(1478), Schedules(1099), Sheets(1123), Spell Check(1191), Tasks(1695), Web forms(1497).

Obsolete: Letters(1194), Questionnaire(1195).

Lists
A central location to manage master lists.

Procedure Codes(1195), Allergies(1221), Clinics(1505), Contacts(1227), Counties(1228), Dental School Classes(1232), Dental School Courses(1233), Discount Plans(1230), Employees(1233), Employers(1235), Insurance Carriers(1237), Insurance Plans(1244), Lab Case(379), Medications(1246), Pharmacies(1249), Problems(1250), Providers(1252), Prescriptions(1264), Referrals(1268), State Abbreviations(1270), Sites(1272), Zip Code List(1273).
Reports

Standard(1276), Graphic(1376), User Query(1382) (Released Queries), Unfinalized Payments

Tools

Most tools require the "Setup" Permission(1118) to access.

Print Screen Tool(1400), Misc Tools (see below), Aging(1423), Audit Trail(1424), Billing/Finance Charges(1428), CC Recurring Charges(1430), Database Maintenance(1434), Evaluations(1439), Kiosk(1444), Kiosk Manager(1444), Mobile Synch(1449), Ortho Auto Claims(1425), Patient Dashboard(1507), Online Payment Management(1563), Public Health Screening(1457), Repeating Charges(1465), Setup Wizard(1467), Dental School Requirements Needed(1478), Web Forms Feature, Wiki(1484), XWeb Transactions(1563)

Misc Tools: Auto-Close Payment Plans(248), Clear Duplicate Blockouts(10), Database Maintenance Pat(1402), Create A to Z Folder(1402), Merge Discount Plans(1405), Merge Medications(1406), Merge Patients(1407), Merge Providers(1408), Merge Referrals(1410), Move Subscribers(1411), Patient Status Setter(1421), Service Manager(1412), Shutdown Workstations(1418), Telephone Numbers(1419), and Test Latency(1420).
Clinics
Only shows if Clinics (1505) is turned on in Show Features. Use the menu to select the default clinic interface. Options available depend on security settings and the logged-on user.

eServices
Mobile Web (1530), Patient Portal (1555), Texting (1610), Web Sched (1584), eReminder (1613), eConfirmation (1620), Misc (1634), eConnector Service (1520)

Alerts
Alerts (1635), Pending Online Payments (1563).

Help
Online Support: Go to Open Dental's Contact page where you can connect to a support technician for assistance and troubleshooting.

Online Help - Contents: Open the User Manual Table of Contents.

Online Help - Index: Opens the User Manual Search page.

Training Videos: Opens the Webinars and Tutorials webpage.

Query Monitor: Opens the Query Monitor (1638) window to allow real-time monitoring of queries to the MySQL database.

Remote Support with Code: Enter Session Code to remotely connect with Open Dental. Session Code is provided by technical support.

Request Features: Open the Feature Requests (1636) system.

Update: Check for and download new versions of Open Dental. See Update (1639).

Support Status: Opens the Support Status window to see if your office is currently signed up for Monthly Support.

About: Open the About (1645).

Change Password
In the Main Menu (592), click File, User Password.
Each user should have a unique Security password only they know. The logged-on user can change their password at any time.

- Note: Users with the Security Admin permission can assign initial passwords when setting up User Security Profiles.
- To force a user to change their password the first time they use it to login, check Require Password Reset in the user’s security profile.
- Password requirements are determined by Global Security Settings. Strong passwords must be at least 8 characters and have at least one number, one uppercase letter, and one lowercase letter. If strong passwords require special characters, it must also contain a symbol such as $, #, &gt;.

To update a password:
1. Enter the current password.
2. Enter the new password. Check Show to display password characters as you type instead of asterisks.
3. Click OK to save.
Note: If passwords do not meet requirements, you will receive a notification message.

Temporary Passwords
A temporary password can be used to initially log on to Open Dental. Once logged on, each user should immediately change their password using the steps above.
1. In the main menu, select Setup, Security.
2. Double click on a user.
3. Click Create / Change Password.
4. Enter the password. Check Show to view the password as you type instead of asterisks.
5. Click OK to save.
6. (optional) To require a password reset when the user first logs on, check Require Password Reset in the user settings.

Email Address Edit
In the Main Menu, click File, User Email Address.
Alternatively, for shared emails, in Email Setup(747), click Add, or double-click on an existing address to edit.

Note: If accessing this window from the Main Menu, File, User Email Address, then this email is specific to a user. No other users will be able to see emails sent to the address.

Enter the email settings. You may need to consult your email provider.

**Username**: The full email address.

**Password**: The password for this email account.

**Use SSL**: Check the box to enable SSL. Uncheck it to disable SSL.

**Outgoing SMTP Server / Outing Port**: Settings used to send email. Implicit SSL ports (e.g. 465) cannot send encrypted email.

**Email address of sender**: This email address is an alias, but not all email providers will recognize it. It will appear in the From address instead of the username (full email address), though the username credentials will still be used. When sending encrypted email, this field is ignored.

**Alias format**: If Sparkly Dental &lt;bob@gmail.com&gt; the recipient will see Sparkly Dental as the sender instead of bob@gmail.com.

**Incoming POP3 Server and Port**: Settings used to receive email.

**User**: The user associated with the email address. Click [...] to select a user.

- **Note**: Editing the user is only available when accessing this area from Email Setup.
- **Users must have the securityadmin permission to change the user assigned to an email address.**
- **The default email address and WebNotify email addresses cannot have a user assigned.**
For troubleshooting help, see Email Errors (1667). For information about public certificate hosting for Direct messaging, see Email Certificate Hosting (759) (used by EHR providers to exchange patient health information with other EHR providers).

User Settings
In the Main Menu (592), click File, User Settings.

- Log off message is suppressed: Check to disable log off warning message. See Log On (1121).
- Theme: Select a user specific theme. Users can set their own theme option must be checked in Miscellaneous Setup (921).

Printer Setup
In the Main Menu (592), click File, Printers.
Use Printer Setup to set default print options for the current workstation. You can leave all settings to the default, or you can control where specific items are printed.

By default, all categories that allow you to set a default printer are listed.

To view a simple version of this window, check **This is too complicated. Show me the simple interface** (see below).

For each category, select the default printer.

- **Default**: The printer used for all categories that have default as the selection.
- **Appointments**: The printer used when printing appointments from the Appointments Module (1).
- **Claims**: The printer used for claims.
- **Labels - Sheet**: The printer used for sheets of Labels (1708).
- **Labels - Single**: The printer used for single Labels.
- **Postcards**: The printer used for postcards.
- **Rx's**: The printer used for Paper Prescriptions (333).
- **Controlled Rx's**: The printer used for prescriptions that are marked as a controlled substance.
- **Multi Rx's**: The printer used for multiple prescriptions on one page. See Rx Manage (337).
- **Statements**: The printer used for Statement (269).
- **Treatment Plans and Perio**: The printer used for Treatment Plans (290) or Perio Chart (382).
- **Receipts**: The printer used for XCharge (OpenEdge)(173) or PayConnect Window (168) receipts.

**Prompt**: Check this box when you want to select a printer before printing. This is useful when you want to select a different printer, print a page range, or make printing adjustments. Uncheck this when you want to immediately print to the selected printer using the printers defaults.

**Simple Interface**
When setting Printer Setup to the Simple Interface, all workstations will also be set to Simple Interface and the printer will be set back to the Windows Default. You will be prompted with a warning prior to making this change.

**Troubleshooting**

Below are common printer issues and troubleshooting methods. Before starting the troubleshooting process:

- Check that adequate paper is in all paper trays and there is sufficient ink.
- Make sure you have selected the correct printer (It is the default in Printer Setup above, or is selected on the Prompt window).

**Problem: Unable to print from Open Dental or Windows.**

Solution: This is likely an issue with your printer drivers or Windows configuration.
1. Make sure your printer drivers are up-to-date and compatible with your Windows version.
2. Restart the printer.
3. If that doesn't work, try restarting the computer.
4. If neither work, this is likely a printer setup issue. You may need to reinstall the printer drivers.

**Problem: Can print from Window, but unable to print from Open Dental.**

Solution:
1. Exit Open Dental, then run Open Dental as Administrator.
2. If that doesn't work, and you have been able to print from Open Dental with the current printer previously, try restarting your computer.
3. If that doesn't work, or your printer has never worked with Open Dental, contact us.

**Problem: Open Dental stops responding when attempting to print.**

Solution:
1. If the printer is a network printer, make sure you have access to the server location.
2. Restart the computer. If the communication between Windows and Open Dental is bad, this should fix it.
3. If still not responding, contact us.

**Graphics Preferences**

In the [Main Menu](592), click File, Graphics.
Graphic settings affect the display of the **Graphical Tooth Chart** (464), the **Graphical Perio Chart** (385), and the graphics displayed on printed Treatment Plans. Settings are specific to the computer where you are working, allowing you to set different graphics preferences for each computer. Users must have the **Graphics Edit** permission to access and change graphic settings.

**DirectX**: This is the latest 3D Microsoft technology. It is recommended if possible. This setting is required to view the graphical perio chart.

**OpenGL**: This is the 3D technology that we used in the past. It works well, but the graphical perio chart will not be available.

**Simple 2D**: Can be used if neither DirectX or OpenGL can be made to work. For example, when using a remote connection, such as Microsoft Terminal Services, GoToMyPC, etc. The simple tooth chart will eliminate all slowness issues over the remote connection. But the tooth chart will not look as nice.

**Options for 3D Tooth Chart**: These are only changed if the graphical tooth chart is not working properly.

- **OpenGL Filters**: Filter the list of graphic formats. These options are only enabled when OpenGL is the selected option.
  - **Hardware Acceleration**: Use one of these formats if you have a graphics card. If you have a graphics controller that is integrated into the motherboard, you might not use this option. In practice, it works best to try it both ways to see which gives you the best result.
  - **Use Double-Buffering**: With these formats, the redraw of the graphics is hidden in a second buffer. This eliminates flicker.
  - **Show All Formats**: All available formats

**Graphics Formats**: Click on the format to use for the tooth chart. The selected format number shows at the top.

**Troubleshooting**
If DirectX is not working properly

1. Install all express/critical Windows Updates.
2. Update the graphics card driver using one of the following:
   1. Try to locate the driver from the computer manufacturer's website.
   2. Try to locate the driver from the graphics card manufacturer's website.
   3. Try to use Windows Update to update the graphics card driver.
3. Install the DirectX End-User Runtimes (June 2010) (only do this if DirectX is still not working).
   o Create a temp folder then download the file to it. This places all files in one location.
   o Run DXSETUP.exe to insert missing DirectX files.
   o Close, then reopen Open Dental.
4. If none of the above steps resolve the issue, install the June 2010 version of the DirectX SDK and restart the computer.

If you cannot get into Graphic Preferences on your computer
You can change the graphic setting from a different computer. Click Setup, Advanced Setup, Computers (778).
If you experience a major error while using this interface, see Troubleshooting.

More Terminology
(Only for the very curious)
- Windowed: Can be drawn on the screen. There are some graphics formats that cannot be drawn to the screen.
- Palette: Instead of millions of colors, there is just a small palette of colors available.
- Depth bits: This is how the coordinates on the Z axis are stored. If there are not enough depth bits available, overlapping doesn't work properly.
- Color bits: The more the better.

Choose Database
In the Main Menu (592), click File, Choose Database.
These settings allow your workstation to locate and connect to the MySQL database. If you install Open Dental on multiple computers, this window shows the first time you run Open Dental on each workstation.

- **Server**: The name of the computer where the MySQL server and database are located. If running on a single computer only, the computer name may be `localhost`.
- **Database**: The database to connect to. Usually this is `opendental`.
- **MySQL User**: Default user is `root`. See MySQL Security to set users and passwords.
- **MySQL Password**: The user password (if you have set MySQL users and passwords).
- **Do not show this window on startup (this computer only)**: Check this box to hide this window on subsequent startups of Open Dental on this workstation.

To save the information, for the next time Open Dental starts up, right-click the Open Dental icon and Run as Administrator, then enter the Choose Database settings.

**Connect to Middle Tier instead**: See Middle Tier. Instead of connecting directly to the database, you have the option to connect to a Middle Tier which handles all of the database interactions. The advantages include better security and speed for multiple offices. Using the middle tier makes it impossible for the user to connect directly to the database. The user will never have access to the MySQL username and password used to access the database. It also prevents injection attacks when writing queries.
Advanced: Use connection string: Allows customizing the MySQL connection parameters (advanced users only). See also Oracle.

Dynamic Mode: Automatically downgrades or upgrades to server version:
- Checked: If the selected server and database are running a Version different than the currently installed version on this workstation, Open Dental will automatically install the server's version of the Open Dental client into a dynamic folder and launch the program from there.
- Unchecked: If the selected server and database are running an older version of Open Dental than the currently installed version, Open Dental will upgrade the database. If the server is running a newer version, the local client will be updated to match.

Note: This option will not be available on the computer designated as the Update Server in Miscellaneous Setup.

For Advanced Users
The settings on this window are stored in the FreeDentalConfig.xml file in the installation directory. This data is not stored in the database because you have not yet established a database connection.

Multiple Databases: Most users will have only one database. However, in Open Dental you have the option of running many databases on the same computer. For example, you could make Backups of your database within its original folder. To access a historical snapshot of the data, simply select a database backup to open. You can also switch between your regular database and a backup that you take home on your laptop for read-only purposes. If you run a dental billing company, each doctor client can retain a separate database (each office must also have a separate Open Dental license).

To switch between databases, use the Database dropdown. This is only available when the Choose Database window appears upon startup.

Troubleshooting
Problem: Connection to the MySQL server has been lost.

Solution: This message pops up when the workstation cannot connect to the MySQL server. Open Dental will attempt to reconnect until connection is successful or the user aborts (Exit Program).

Problem: Error regarding too many connections.
Solution: In the my.ini file on the server, change the max_connections to 3,000.
Note: For users on MySQL 5.5, this will use RAM on the server computer as connections are made. For users on MySQL 5.6, it will immediately reserve RAM on the server computer. 3,000 connections is roughly 1GB regardless of MySQL versions.

FreeDentalConfig.xml
See Choose Database.

The FreeDentalConfig.xml file stores database connection information.
When you select options on the Choose Database Window, information is stored in this file. If using advanced options such as Middle Tier or connection strings, it can also change the tags in the file. The file is located in the Open Dental installation directory. If it is missing or deleted, Open Dental will recreate it the next time it is run.

Note: If using Command Line Arguments to launch Open Dental those options will not be saved to the FreeDentalConfig.xml file.

Below is a description of the .xml tags you may see in the file. This table has been ommitted.

**Appointments Module Preferences**

In the Main Menu(592), click Setup, Appointments, Appts Preferences.
Alternatively, click Setup, Module Preferences (927), Appts tab.

The following preferences determine functionality handled in the Appointments Module (1).

**Broken Appointment Automation:** Determines what happens when breaking appointments. There are several options; you can select one or a series of actions. See Break Appointment (55).

- **Broken appointment procedure type:** Determines the procedure(s), if any, a user is prompted to add to the patient’s chart when an appointment is broken.
  - None: Do not prompt user to add any procedure.
  - Missed: User will be prompted to add completed procedure D9986 (missed appointment).
  - Cancelled: User will be prompted to add completed procedure D9987 (cancelled appointment).
  - Both: Give user the option to add a completed D9986 or D9987.

- **Make broken appointment commlog:** Determines whether or not a user is prompted to enter a Commlog (1654) when an appointment is broken.
  - Checked: Open the commlog window.
  - Unchecked: Do not open the commlog window.

- **Make broken appointment adjustment:** Determines whether or not a user is prompted to add Adjustments (203) when an appointment is broken.
  - Checked: Open the Adjustment window.
  - Unchecked: Do not open the Adjustment window.

- **Broken appt default adj type:** Select the default adjustment type to assign to broken appointment adjustments. Only Additions (+) adjustments types can be selected.

**Time Arrived trigger:** Select the confirmed status that will trigger an automatic time entry in the Time Arrived field on the Edit Appointment (20), and add the patient to the Waiting Room (16). Customize options in Definitions, Appt Confirmed (see Confirmation Status (17)).

**Time Seated (in op) trigger:** Select the confirmed status that will trigger an automatic time entry in the Time Seated field on the Edit Appointment window, and remove the patient from the Waiting Room. Customize options in Definitions, Appt Confirmed.
**Time Dismissed trigger**: Select the confirmed status that will trigger an automatic time entry in the Time Dismissed field on the Edit Appointment window. Customize options in Definitions, Appt Confirmed.

**Search Behavior**: Set the behavior for the Search feature *(Pinboard(14))*.
- ProviderTime: Compares the needed provider time (indicated in the time pattern of the appointment) with available provider time (indicated by the time bar at the left of the appointment schedule), then returns the first available time slots for each of the next 10 available days.
- ProviderTimeOperatory: Uses the same search criteria as ProviderTime, but only returns time slots when the provider is available and the provider's operatory (or operatories) is available, for each of the next 10 available days.

**Appointment time locked by default**: Set the default setting for the Time Locked box on the Edit Appointment window.
- Checked: The Time Locked box will default to checked, and added procedures will not automatically adjust the appointment time.
- Unchecked: The Time Locked box will default to unchecked.

**Appointment bubble max note length (0 for no limit)**: Enter the maximum appointment note length, in characters, that shows when you hover over an appointment in the schedule. If 0, there will be no maximum length and the appointment bubble will automatically resize to accommodate the entire appointment note.

**Filter the waiting room based on the selected appointment view**: Determines which patients show in the waiting room.
- Checked: Only show patients who have an appointment scheduled in an operatory in the current Appointment View.
- Unchecked: Show patients scheduled in any operatory.

**Waiting room alert time in minutes (0 to disable)**: Enter a value in minutes to flag patients whose wait time has exceeded this value. An entry of 0 disables this feature. If a value is entered, text color of patients in the waiting room will change to the waiting room alert color (below) when their wait time exceeds this value.

**Reset Calendar to today on Clinic select**: Determines the date of the appointment calendar when a user changes the clinic via the Main Menu. Only visible when clinics is enabled.
- Checked: The date will reset to today's date.
- Unchecked: The date will remain the same.

**Add daily adjustments to net production**: Determines if adjustments are included in the net daily production shown in the Appointments module. See *Production Totals*(15).
- Checked: The net daily production total will include adjustments.
- Unchecked: The net daily production total will not include adjustments.

**Force op's hygiene provider as secondary provider**: Determines the default hygienist when scheduling an appointment in an operatory.
- Checked: The hygienist of the operatory is always assigned as the hygienist on the appointment, even if *none*.
- Unchecked: The hygienist of the operatory is assigned as the hygienist unless it is *none*. In that case, the patient's secondary provider is assigned.

**Appointments Module production uses operatories**: Determines how the daily production value in the Appointments module is calculated.
- Checked: Calculate gross and net production based on the procedures in operatories that show in the appointment view.
- Unchecked: Calculate gross and net production based on the procedures attached to appointments for providers whose bars show in the appointment view.

**Appointments require procedures**: Determines whether or not new appointments must have procedures attached.
- Checked: At least one procedure must be attached to an appointment before it can be created.
- Unchecked: Appointments can be created with no procedures attached.
**Appointment without procedures default length:** Determines default length of an appointment when no procedures are attached.

**Allow setting future appointments complete:** Determines whether or not appointments in the future with no procedures attached can be set complete.
- Checked: Appointments with a future dates can be set complete.
- Unchecked: Appointments with a future date cannot be set complete.

Note: If you need to be able to set future dated appointments with attached procedures complete, you will additionally need to enable the Allow Future Dated Transactions option in Account Module Preferences (693).

**Allow setting appointments without procedures complete:** Determines whether or not appointments with no procedures can be set complete.
- Checked: Appointments that have no procedures attached can be set complete.
- Unchecked: Appointments that have no procedures attached cannot be set complete.

**Enforce clinic specialties:** Determines whether or not specialties are enforced when scheduling patients.
- Don't Enforce: Allows scheduling appointments in any clinic regardless of specialty.
- Warn: Warn user when scheduling a patient whose specialty does not match the specialty assigned to the clinic.
- Block: Block user from scheduling a patient whose specialty does not match the specialty assigned to the clinic.

**Allow 'Block appointment scheduling' blockouts to replace conflicting blockouts:** Determines what happens to overlapped blockouts.
- Checked: Blockout types that have Block Appointment Scheduling checked will replace any existing blockouts it would overlap.
- Unchecked: Blockouts will not be allowed if they overlap an existing blockout.

**Do not allow recall appointments on the Unscheduled List:** Determines whether recall appointments will appear in the Unscheduled List (41).
- Checked: Recall appointments cannot be sent to the Unscheduled list. Option to delete the appointment, or leave it where it currently is, will be displayed.
- Unchecked: Recall appointments are allowed to be sent to Unscheduled List.

Note: In some circumstances users may still be able to manually send broken recall appointments to the unscheduled list. This preference is intended to prevent accidents.

**Number of days out to automatically refresh appointment module (-1 for all):** Determines the number of days moving forward from today that signals are added to the database. This preference is useful for large offices who experience slowness in the Appointment Module.

**Prevent changes to completed appointments with completed procedures:** Determines available functionality for completed appointments with completed procedures attached.
- Checked: Prevents users from making certain changes to a completed appointment with completed procedures attached. This preference prevents breaking the appointment, deleting the appointment, changing the appointment status, or sending the appointment to the Unscheduled List. Also prevents completed procedures from being detached from completed appointments.
- Unchecked: Allows any changes to completed appointment with completed procedures attached.

**Appointments allow overlap:** Determines if appointments are allowed to overlap in the same operatory.
- Checked: Allows multiple appointments to overlap in a single operatory.
- Unchecked: Prevents appointments from overlapping in a single operatory.
- Filled: When filled Open Dental will use the recommended setting. This preference is recommended to be checked. Click to change the preference to checked or unchecked.

**Appearance**
Default appointment bubble to 'disabled' for new appointment views: Determines the default setting for Disable appointment bubbles check box when adding new Appointment Views(7).
- Unchecked: The Disable appointment bubbles box is unchecked.
- Checked: The Disable appointment bubbles box is checked.

Appointment bubble popup delay: Set the behavior for bubble popups (if they are enabled).
- Unchecked: There will be no delay.
- Checked: A slight delay will prevent the bubble popup unless you intentionally hover over an appointment.

Use solid blockouts instead of outlines on the appointment book: Determines the appearance of Blockouts(10).
- Unchecked: Blockouts will be outlined only.
- Checked: Blockouts will show with a solid background.

Adding a procedure will cause the Broken Appointment Procedure window to open each time an appointment is broken.

Show ! on appts for ins not sent, if added to Appt View (might cause slowdown): Enable or disable the exclamation point that shows in an appointment to indicate procedures have not been sent to insurance. For very large offices, enabling this option might slow down the Appointments module. The exclamation point does not show if a claim has been created for the procedure.
- Checked: An exclamation mark will show when any member of a family has procedures not sent to insurance yet. InsToSend[] must also be added to the appointment view and there must be at least one completed procedure with an estimate waiting to be sent (within the last year).
- Unchecked: The exclamation point will not show.

Waiting room alert color: Click the colored square to Color(837) of text when a patient's wait time exceeds the waiting room alert time (set above).

Appointment time line color: Click the colored square to select the color of the time line that shows in the appointment schedule.

Appointment Module defaults to week view: Set whether the appointment schedule defaults to week or day view. You must restart Open Dental for this change to take effect.
- Checked: The default will be week view.
- Unchecked: (default) The default will be day view.

Appointment click delay: Select a delay, up to one second, that will occur when a user double clicks an appointment to open it in the Edit Appointment window. The delay will prevent accidental adding or selecting of procedures within the delay time.

Refresh every 60 seconds. Keeps waiting room times refreshed: We recommend keeping this checked so that the Appointments module is guaranteed to refresh a minimum of every 60 seconds. Also see Miscellaneous Setup(921), Process Signal Interval in seconds.
- Checked: The entire appointment module will refresh at least every 60 seconds.
- Unchecked: At a minimum, the red time line will refresh every 60 seconds.

Appointment font size. Default is 8. Decimals allowed: Alter the font size used for appointments.

Width of provider time bar on left of each appointment: Alter the width (in pixels) of the provider timebar displayed on the left edge of appointments. Default is 11. Set the width to 0 to remove the bar entirely.

Confirmation Setup
In the Main Menu(592), click Setup, Appointments, Confirmations.
On the Setup Confirmation window, define the default message text for confirmations sent from the Confirmation List (text messages, emails, and postcards). You can also set the default appointment confirmation status to apply when a confirmation is sent.

Note: To set default options for printing postcards and email logic, see Setup Recall (632).

Hint: Use eReminders and eConfirmations Feature to automate the confirmation process. These eServices send automated text or email messages to remind patients about upcoming appointments. Patients can even electronically confirm, which changes their appointment confirmation status. Click Automated eConfirmation and eReminder Setup to access the setup area.

The Messages grid lists the message text used for postcard, email, and text message confirmations sent from the Confirmation List.

- **Mode**: When the message will be used based on the method of delivery (Postcard, Email, Text).
- **Second column**: General guidance about the message and what variables are available for use.
- **Message**: The text itself.

### Customize Message Text

1. Double click on a row.

2. Enter the subject or message text. Insert variables as needed.
3. Click OK to save.

Text with brackets indicates variables that pull information directly from the database. For example:

"[NameF], we would like to confirm your dental appointment on [date] at [time]"

might look like this in the message:

"John, we would like to confirm your dental appointment on 3/24/2018 at 9:00 a.m."
Available variables:
- **NameF**: Patient first name.
- **NameFL**: Patient first and last name.
- **date**: Appointment date.
- **time**: Appointment time.

A message segment is 160 characters. Each additional message segment will result in additional charges.
- A carriage return adds two characters.
- The following characters are allowed. If other characters are used the message will fail.
  a-z, A-Z, 0-9, . , : ; ! ? ( ) ~ = + - _ \ / @ $ # & %

Note: Regular email and text messaging are not secure methods of sending PHI. See Encryption of Data at Rest and in Transit.

**Confirmation Status Options**
The status options determine which **Confirmation Status** (17) is automatically applied to the appointment when a confirmation is sent.
- **Status for emailed confirmation**: The confirmation status applied to the appointment when a confirmation is emailed from the Confirmation List.
- **Status for texted confirmation**: The confirmation status applied to the appointment when a confirmation is texted from the Confirmation List.

**Postcard Options**
See Setup Recall (632) to select Postcard options (per page, return address, offsets) that affect confirmation postcards.

**Appointment Field Defs**
In the **Edit Appointment** (20) window, on the bottom left, are the custom appointment fields.

<table>
<thead>
<tr>
<th>Appt Fields</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ins Verified</td>
</tr>
<tr>
<td>Misc</td>
</tr>
<tr>
<td>Pat Info Updated</td>
</tr>
</tbody>
</table>

Custom appointment fields are a more organized alternative to notes

**To enter information in a field:**
1. Open the Edit Appointment window.
2. Double-click a field.
3. Type the information, or select from a pick list of answers.
4. Click OK to save.

Information entered in a custom appointment field can also be displayed in an appointment box on the schedule (Appointment Views(7)).

**Set up Custom Appointment Fields**
To create an appointment field:
1. In the Main Menu(592), click Setup, Appointments, Appointment Field Defs.

2. Click Add, or double click an existing field to edit.
Field Name: Enter the name of the field.
Field Type: Select the type of field.
- Text: Users can enter any free-form text.
- PickList: Users will select from a list of items. Enter one item on each line.

Click OK to save.

Hide / Remove a Custom Appointment Field
If no data has been entered in custom appointment field, it can be deleted.
1. On the Appointment Fields Defs window, double click the appointment field.
2. Click Delete.

Once data has been entered in a custom appointment field, it can only be hidden, not deleted.
1. On the Appointment Field Defs window, click Setup to open the Field Display window.
By default, all custom appointment fields already setup for AppointmentEdit will display.

- **Visible Fields**: Lists all appointment fields currently showing on the Edit Appointment window.
- **Hidden Fields**: Lists appointment fields that have been marked hidden, and do not show on the Edit Appointment window.

2. Highlight a Visible Field, then click the right arrow to move it to Hidden Fields (and mark it hidden). To unhide a field, move it back to Visible Fields.
3. Click OK to save.

**Appointment Rules**

Appointment rules prevent double booking of a provider's time for certain procedures.

In the **Main Menu** (592), click Setup, Appointments, Appointment Rules.
Rules can be created for a single procedure code or a range of procedures codes.

Click **Add** to create a new appointment rule, or double-click a rule to edit or delete it. There are no default appointment rules.

**Description**: Enter the identifying name.

**Code Start/End**: Enter the procedure code(s) this rule will apply to. For one procedure code, enter the same code in each field. For a range of procedure codes, enter the start and end procedure code.

**Is Enabled**: Check to enforce the appointment rule. Uncheck to disable the rule.

Click **OK** to save.

To permanently remove a rule, click **Delete**.

This example is a typical root canal rule that prevents RCT procedures from being double booked. If someone attempts to double book one of the procedures in the code range, a warning message will appear.
Because the rule only considers provider time when blocking, an overlap of non-provider time might still occur (e.g. about 20 minutes).

If double booking of procedures is allowed (no appointment rules for a procedure), conflicts show in the Provider Time Bars on the appointment schedule. See Time Bars(7).

**Double Booking WebSched**
If you would like to permit double booking providers through Web Sched based on your appointment rules, see Web Sched New Patient(1586) and/or Web Sched Recall(1600). Uncheck Prevent double booking.

**Appointment Types**
Use appointment types to customize appointment background colors, time patterns, and procedures.

In the Main Menu(592), click Setup, Appointments, Appointment Types.

![Setup Appointment Types](image)

To assign appointment types to appointments:
- When setting up the appointment type, enable the prompt for all new patient appointments.
- On the Edit Appointment(20) window, select the appointment type.
- For Web Sched New Patient, associate appointment types to Definitions: Web Sched New Patient Appt Types(894).

**Add Appointment Types**
1. In the Setup Appointment Types window, select your preferred settings.

*New appointments prompt for appointment type*: Set the default appointment type behavior when adding a new appointment. If checked, creating a new appointment will trigger the Select Appointment Type window to pop up. If unchecked, the window will not appear.
**Warn users before disassociating procedures from an appointment:** Set the default behavior when removing procedures from an appointment. If checked, a warning pops up when the user changes the appointment type of an existing appointment if the new type has different procedures than the current type. If unchecked, you can dissociate procedures from an appointment via appointment type with no warning.

Click Up or Down to reorder appointment types.

2. Click Add or double click an existing type to edit.

3. **Name:** Enter the name of the appointment type.
4. **Color:** Associate a background color to the appointment type. Click the square to select a Color (837). Or click None to clear a color selection. Appointment type color overrides the provider color. Changing the color of an appointment type will not change the background color of existing appointments.
5. **Procedures:** Click Add to attach procedures to the appointment type. To select multiple procedures from the list of Procedure Codes (1195), click and drag, or press SHIFT while clicking, then click OK. To remove a procedure, highlight it then click Remove.
6. **Time:** Indicates the time pattern of the appointment type. By default, it will use the time pattern of attached procedures. To change the time pattern, use the slider bar on the left. Drag the slider up or down to increase or decrease appointment length. Click each square to toggle between X (provider) and / (non-provider) time. By default, each square in the time bar is 10 minutes. To change the default setting, see Time Increments in Appointment View Setup (621).

To reset the time pattern to use procedure time pattern, click Clear.

Also see Time Pattern Logic below.

7. Click OK to save.

**Hidden:** Hide this appointment type as a selection on the Edit Appointment window

**Changing an Appointment Type**
When an appointment type is changed, existing appointments with that type remain unchanged. Double-click the appointment and reselect the appointment type to update.

Changing an appointment type on an existing appointment will treatment plan the procedures for the new appointment type. The original procedures will also remain treatment planned. Manually delete the procedures you do not want in the Treatment Plan module, Procedures grid.

Changing the appointment type from one with a custom time pattern or attached procedures to one with no time pattern will not change the time pattern of the appointment.

**Time Pattern Logic**
The appointment time is recalculated based on the following logic:

- If the appointment type has procedures attached and a custom time pattern, the custom time pattern is used.
- If the appointment type has procedures attached but does not have a custom time pattern, the procedure time pattern is used.
- If the appointment type has no procedures attached and no custom time pattern, the appointment will not have a time pattern.

**Note: Logic for MobileWeb Appointments**

- If an appointment type is selected, and the time duration entered matches the appointment type, the Appointment Time Pattern is retained.
- If no appointment type is selected, or the time duration entered does not match the appointment type, the time pattern will add assistant time to meet the full time duration.

**Appointment View Setup**

In the [Main Menu](#)(592), click Setup, Appointments, Appointment Views.
Appointment Views determine the operatories and providers that show in the Appointments Module and the information that shows in a view's appointment box.

Clinics: If using Clinics, views are associated with specific clinics. All corresponds to Headquarters. Users can only access appointment views for clinics they have access to.

Views: Lists the appointment views already setup. Each view is associated with a function key (e.g. F1). The Fkey is determined by the view's order on the Appointment Views window. To change a view's sort order, highlight it, then click the Up/Down Arrows. Double click a view to edit.

Time Increments: Set the time increment (5 minutes, 10 minutes, 15 minutes). The time increment affects all views.

Click Add to create a new appointment view, or double click an existing view to edit. See Appointment View Edit.

Appointment View Edit
In the Appointment View Setup window, double-click a view.
Description: The identifying name of this appointment view.

Rows per Time Increment (usually 1): Affects the row height for time increments. Enter a number between 1 and 3.

Minimum Op width (default 0) (turns on hscroll): Enter the minimum width of an operatory (in pixels). If the minimum width of each operatory exceeds the width of Open Dental, a horizontal scroll bar will be added to the bottom of the Appointments Module to view appointments.

Schedule Start Time: When Open Dental is first launched, the appointment schedule automatically scrolls to a default start time. After Open Dental is launched, the scroll bar will remember the last position it was in and stay there. The options below affect the start time.

- **View Start Time on Load**: Set a fixed default start time. This option is only used when start times are not determined dynamically.
- **Dynamic start time based on schedule**: When checked, the schedule will automatically scroll to whichever comes first: the start time of the earliest appointment or the scheduled start time earliest scheduled provider. Only providers in operatories included in the view are considered. Operatories not assigned a provider will consider the default provider's schedule. If no operatory has a scheduled provider or appointment, the View Start Time on Load value is used. See Schedule Setup(1099).

Disable appointment bubbles: Set whether or not a bubble popup shows in this appointment view when hovering over an appointment in the schedule. Disabling the bubble popup is useful for privacy (so PHI is not visible) or for better system performance. When checked, bubble popups are turned off. When unchecked, bubble popups will show. The default
setting is determined by the preference in Appointments Module Preferences(608) for Default appointment bubble to disabled for new appointment views.

**Assigned Clinic:** If using clinics(1505), select the clinic associated with this view. The view will only be available when this clinic is selected in the main menu. All = Headquarters. Defaults to the clinic selected on the Appointment Views window.

**View Operatories:** Highlight the operatories that will show in the view. If using clinics, only operatories associated with the assigned clinic list. Click and drag or press Shift or Ctrl while clicking to select multiple operatories. At least one operator must be selected. Sort order is based on Operatories(628) order.

**Note:** Screen size controls how many operatories can show at one time in a view. Usually six to seven operatories can show at once.

**Only show operatories for scheduled providers:** Check this box to dynamically show provider operatories based on time of day. Only operatories highlighted in View Operatories are considered. Enter the time restriction in one of the following boxes (e.g. 12 pm).

- **Only if before time:** Show operatories for providers whose schedule starts and ends before this time.
- **Only if after time:** Show operatories for providers whose schedule starts and ends after this time.

Example: Providers are assigned to different operatories after lunch. Create two appointment views, one for morning and one for afternoon.

Morning appointment view: This view will show operatories for providers whose time block in the schedule ends before 12:01 pm.
1. Highlight all operatories.
2. Check the Only show operatories for scheduled providers box.
3. Enter for Only if before time enter 12:01 pm

Afternoon appointment view: This view will show operatories for providers whose time block in the schedule starts after 12:02 pm.
1. Highlight all operatories.
2. Check the Only show operatories for scheduled providers box.
3. Enter for Only if after time enter 12:02 pm

**View Provider Bars:** Highlight the provider Time Bars(7) to show in the view. Time bars show on the left of the schedule in the appointment color of the provider.

**Appointment Box**
The selections described below affect what information shows in an appointment box and where. To customize what shows in the appointment bubble, see Display Fields(900), Appointment Bubble.

Example: This appointment view has the following fields added:

- **Main List:** PatientNameF, WirelessPhone, Age, Provider, Procs, and TimeAsktoArrive,
- **Upper Right Corner:** MedorPreMed[+], Hasins[I], and ConfirmedColor.

**Available Rows:** A list of available data that can be shown.
- Address
- AddrNote: Address and phone note.
- Age: As calculated on Edit Patient Information window.
• ASAP: Display ASAP when the appointment status is ASAP.
• ASAP[A]: Display A when the appointment status is ASAP.
• AssistantAbbr: The assistant’s abbreviation.
• Birthdate: As entered in the Edit Patient Information window.
• ChartNumAndName: Chart number and patient last name, first name.
• ChartNumber: Chart number only.
• ConfirmedColor: Display a colored circle in the appointment box to indicate Confirmation Status(17). Define colors for each confirmation status in Definitions, Appt Confirmed.
• CreditType: As entered in the Edit Patient Information window.
• DiscountPlan: The patient’s Discount Plan(1230) name.
• EstPatientPortion: Estimated patient portion for attached procedures. (patient portion = gross production - estimated insurance write-offs - insurance estimates). For estimates to calculate correctly you must chart the procedure from the Chart Module then attach them to the appointment. If procedures are added directly to the appointment, you must click into the Treatment Plan Module to update the estimates.
• Guardians: Name of person marked as Guardian in Family Relationships(74).
• HasDiscount[D]: Display D when patient has a discount plan.
• HasIns[I]: Display I when patient has insurance.
• HmPhone: Home phone number.
• InsToSend!: Display an exclamation point (!) on patient appointments when there are completed procedures within the last year that have not been sent to insurance. This will show for a patient if any family members have an unsent procedure. We recommend placing it in the Upper Right Corner. For this to show, also select Show ! at upper right of appts for ins not sent in Appointment Module Preferences. The exclamation point won’t show if a claim has been created for the completed procedure or the insurance estimate is $0.
• Insurance: The patient’s primary and secondary insurance carriers. Does not show insurance plans marked as medical.
• Insurance Color: Displays insurance carrier name with a colored background as set in the Carriers(1237) window. Color only appears if used in Main List. Only displays primary insurance.
• IsLate: Display [L] when a patient is late for an appointment. A patient is considered late if they have no time arrived entered on the Edit Appointment window or if the time arrived value is later than the appointment start time.
• Lab: Show the status of Lab Cases(379). We recommend changing the text color to red as well.
• LateColor: Indicate a patient is late for their appointment by changing the appointment’s color. A patient is considered late if they have no time arrived entered on the Edit Appointment window or if the time arrived value is later than the appointment start time.
  o LateColor overrides provider and appointment type color.
  o The appointment color will not change from Late Color unless the patient's Time Arrived is updated to show the patient was not late.
  o Completed late color appointments will change to completed appointment color.
• MedOrPremed[+]: Display + to indicate patient has Premedicate checked, medical urgent notes, allergies, and/or problems.
• MedUrgNote: Medical Urgent Note entered in the Medical Chart(466).
• NetProduction: Net production of procedures attached to the appointment. (net production = gross production - estimated insurance write-offs - adjustments attached to procedures). Add to view to see the Daily Prod sum at the right of the Appointments module. See Production Totals(15).
• Note: The Appointment Note entered on the Edit Appointment window.
• PatientName: The patient's first and last name.
• PatientNameF: The patient’s first name
• PatientNamePref: The patient's preferred name.
• PatNum: Patient number assigned by Open Dental.
• PatNumAndName: Patient number and patient last name, first name.
• PremedFlag: Display Premedicate if Premedicate is checked in the Chart Medical area.
• Procs: List abbreviations for procedures attached to the appointment on a single line, separated by commas. Text will wrap to next line if too long for a single line.
• ProcsColored: See Proc Appt Colors(626).
• Production: Show the sum of the fees for all procedures attached to the appointment for providers who have a provider time bar showing. Add to view to see the Daily Prod sum at the right of the Appointments module. See Production Totals(15).
• Prophy/PerioPastDue[P]: Displays a P icon if perio recall is overdue.
• Provider
• RecallPastDue[R]: Displays an R icon if recall is overdue.
• TimeAskedToArrive: Display the time before the appointment that the patient has been asked to arrive to the office. See Time Ask to Arrive(58).
• WirelessPhone
• WkPhone: Work phone number.

Appt Field Defs: The available Appointment Field Defs(614).

Patient Field Defs: The available Patient Fields(687).

Main List: The fields listed here align with the left margin of the appointment box. Double click an item to change its text/background color or to move it to a different location.

Upper Right Corner: The fields listed appear in the upper right corner of the appointment box. Whether the information is stacked vertically or horizontally is based on the UR stack behavior selection. It can be useful to organize data that displays as symbols in the upper right (e.g. I, A, [L]). Double click an item to change its text/background color or to move it to a different location.

Lower Right Corner: The fields listed here appear in the lower right corner of the appointment box. Whether the information is stacked vertically or horizontally is based on the LR stack behavior selection. Double click an item to change its text/background color or to move it to a different location.

Proc Appt Colors
In Appointment View Setup(621), click Proc Colors.

When the ProcsColored field is added to Appointment Views, procedures within a defined code range can show in a different text color. In addition, a view can optionally show the last date a procedure in the range was completed.

1. Add the ProcsColored field to the appointment view. See Appointment View Edit(622).
2. Click Add or double click a code range to edit.
3. **Code Range**: Enter the procedure code range the text color will apply to.
4. Click **Change** to select the text color to apply.
5. **Show Previous Date** (optional): To show the last date one of the procedures within the range was completed, check **Show previous date**. For example, if previous BWs were taken in March of 2008, then 4BW (3/08) would show. The date for a single patient will always be the most recent of any code in that range. To list the most recent date of a specific procedure code, add another range for a single procedure code.
6. Click OK to save.

Note: Changes will be immediately reflected in new appointments. To apply any changes to existing appointments run the Appt Procs tool in **Database Maintenance** (1434), Tools tab.

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**Insurance Verification Setup**

In the **Main Menu** (592), click Setup, Appointments, Insurance Verification.

The default criteria for the **Insurance Verification List** (49) can be set via the Setup menu. These settings are also used to determine which patients are checked during a batch insurance verification using **Scheduled Processes** (810).

- **Scheduled appointment in**: Set the default for **Days until scheduled appointment**.
- **Plan benefits haven't been verified in**: Set the default value, in days, for **Plan benefits haven't been verified in**.
- **Patient eligibility hasn't been verified in**: Set the default value for **Days since patient enrollment**.
Past due appointments up to: Set a value, in days, that determines when verifications are considered 'past due' and show on the Past Due tab. The default is 1.

Insurance Verification List defaults to the current user:
• Checked: For User selection defaults to the logged-on user.
• Unchecked: For User selection defaults to All Users.

Exclude patients with insurance plans marked as Do Not Verify:
• Checked: Exclude insurance benefit verifications (Ins) when a patient's insurance plan is marked Don't Verify on the Insurance Plan(81) Edit Window.
• Unchecked: The Don't Verify checkbox is not considered.

Exclude Patient Clones:
• Checked: Exclude Clone(145).
• Unchecked: Include patient clones.

Always reverify service year plans:
• Checked: When a plan's benefit renewal date is after the last verified date, verifications will re-list to remind staff to re-verify benefits.
• Unchecked: Benefit renewal dates will not be considered, only verification filters.

Click OK to save.

Operatories
In the MainMenu(592), click Setup, Appointments, Operatories.

When an appointment is scheduled in an operatory, the operatory's default provider (or hygienist) and clinic are assigned.

Operatories sort order affects the left to right order of operatories in Appointment Views(7).
• Click the Clinic dropdown or [...] to filter by clinic.
• To change sort order, use the up/down arrows on the right. If a specific clinic is selected, the operatory you are moving cannot belong to a Headquarters appointment view.
Add or Edit an Operatory
On the Operatories window, click Add, or double-click an existing operatory to edit.

**Op Name**: Enter the label for the operatory in the Appointments Module schedule. We recommend keeping it short. Two line titles will wrap, but longer titles will be cut off.

**Abbrev (max 5 characters)**: Enter the abbreviation to identify this operatory in various lists throughout the program.

**Clinic**: Select the clinic associated with this operatory. Defaults to the clinic selected on the Operatories window. When setting up appointment views, operatory clinic assignment affects which operatories can be assigned to the appointment view. For example only clinic A operatories can be assigned to clinic A appointment views.

**Provider**: Select the default provider assigned to appointments scheduled in the operatory. The provider determines the operatory's color in the appointment schedule (based on the provider's appointment color). Clinics: If providers are restricted to clinics in Security, only providers available for the selected clinic are options. User Edit

If operatories are assigned to provider time blocks in the schedule, it overrides the operatory provider. Schedule Setup

**Hygienist / Is Hygiene**: Select the default hygienist assigned to appointments scheduled in the operatory. If the hygienist is the main provider for this operatory, also check Is Hygiene to assign the hygienist as the default provider when appointments are scheduled in this operatory.

Note: To assign the dentist to all appointment procedures placed in a Provider Only operatory (including hygiene procedures), set the dentist as both the Provider and Hygienist for the operatory. Otherwise, hygiene procedures (e.g. PA's) may be assigned to the hygienist even though scheduled in a provider operatory.

Optional settings:
- **Set Prospective**: Mark this as an operatory for prospective patients only. Any patient scheduled in this operatory will be given a patient status of prospective (Edit Patient Information). If the appointment is moved to a non-prospective operatory, the patient status will automatically change to patient. This is useful in large clinics that frequently set tentative appointments for patients that may not show up.
**Web Sched Settings**: These settings only affect Web Sched Feature eServices.
- **Is Recall**: Consider this operatory when determining available time slots for Web Sched Recall appointments. Web Sched Recall(1600)
- **New Pat Appt Types**: Indicates Web Sched New Patient Appointment Types associated with this operatory. Only these appointment types can be scheduled in this operatory, using Web Sched New Patient. Click [...] to select appointment types.

![Definition Picker](image)

Highlight the appointment type(s) then click OK. Also see Definitions: Web Sched New Patient Appt Types(894), Web Sched New Patient(1586).

**Update Provs on Future Appts**: See Update Provs on Future Appts(54).

Click OK to save operatory settings.

**Combine Operatories**

Some databases may have duplicate operatories. These operatories can be merged. Merging affects all appointments in selected operatories.

In the Operatories window, select multiple operatories with Ctrl + click, click and drag, or Shift + click.

Click Combine. A confirmation message will appear. Click OK to continue.

![Operator Pick](image)

Highlight the operatory to keep, then click OK.

If appointments are scheduled in both operatories but do not overlap, a message will ask to move the appointments into the merged operatory. Click OK to automatically move the appointments.

If appointments are scheduled in both operatories that do overlap, they will need to be manually moved before the
operators can combine. A warning message will appear. Click OK to view a list of conflicting appointments. This list can be printed. When all conflicts are resolved, reopen the Operatories window to combine.

Duplicate operatories will be marked hidden and appointments merged.

**Remove an Operatory**
To remove an operatory as a selection option for appointment views and various lists, hide it. Hiding an operatory is not allowed if future appointments are scheduled in it. Operatories cannot be deleted.
1. On the Operatories window, double click the operatory.
2. Check the Is Hidden box.
3. Click Save.

**Prompts to Change Provider**
When you move an appointment from the Pinboard to the appointment schedule, or from one operatory to another, you may be prompted to change the provider. If operatories are assigned to default providers, or to provider time blocks in the schedule, this is often what you want to do.

To turn the prompt off:
1. Do not assign providers to operatories (Provider or Hygienist).
2. Also make sure provider time blocks are not assigned operatories in the daily schedule.

**Setup Reactivation**
In the **Main Menu** (592), click Setup, Appointments, Reactivation.

Use the reactivation setup window to determine your preferred settings for the **Reactivation List** (33).

Reactivation must be enabled in **Show Features** (806) for this window to be available.

**Reactivation Messages**
The Messages grid lists the email subject and body, postcard, and text message for reactivation messages sent from the Reactivation List.

- **Mode**: The method of delivery (email or postcard).
The bracketed text are variables which pull information directly from the database.

Available variables:

[NameFL]: Patient first and last name.

[NameF]: Patient first name only.

[FamilyList]: List first name and recall due date of all family members (if Group Families is selected).

[ClinicName]: Clinic name (patient's default clinic).

[ClinicPhone]: Clinic phone number.

[PracticeName]: Practice name.

[PracticePhone]: Practice phone.

[OfficePhone]: Uses clinic phone number if available, otherwise inserts practice phone.

**Reactivation Status Options**
The status options determine which recall status is automatically applied when a reactivation message is sent.

Customize options in [Definitions: Recall / Unsched Status](887).

**Status for mailed Reactivation**: The status applied when a recall postcard is printed.

**Status for emailed Reactivation**: The status applied when a recall reminder is emailed.

**Status for texted Reactivation**: The status applied when a recall reminder is sent via text message using Web Sched Recall.

**Status for emailed and texted Reactivation**: The status applied when a recall reminder is emailed and texted using Web Sched Recall.

**Reactivation List Default View**
The following options affect what shows in the Reactivation List by default.

**Group Families**: Determines default setting for grouping families.
- Checked: Families will group together.
- Unchecked: Families will not group together.

**Days Past**: Determines the default Start Date.

**Contact Rules**
Determines the rules for contacting patients on the Reactivation List.

**Contact Interval (days)**: Number of days between contact for a patient.

**Max # Reminders (e.g. 4)**: Maximum attempts allowed to contact a patient.
Set up recall reminder messages, reminder intervals, and the Recall List default options.

In the **Main Menu** (592), click Setup, Appointments, Recall.

### Recall Reminder Messages

The Messages grid lists the email subject, body, and postcard/text message for recall reminders sent from the Recall List.

**Remind#:** The re (first reminder, second reminder, etc.).

**Mode:** When the message will be used based on the method of delivery (Email, Postcard, WebSched Email, WebSched Text).

**Third column:** General guidance about the message and its use.

**Message:** The message text. When multiple family members are sent a Web Sched Recall reminder, the message is automatically aggregated using a standard message format that cannot be changed. See [Web Sched Recall](1600). A text message segment is 160 characters. Each additional message segment will result in additional charges.

- A carriage return adds two characters.
- The following characters are allowed. If other characters are used the message will fail.

  a-z, A-Z, 0-9, , :, ; ! ? ( ) ~ = + - _ \ / @ $ # & %

To change the email subject line or email, postcard, and text message for a Remind#, double-click on the Message for the corresponding Remind# and Mode. Enter the subject or message text and insert variables as needed (see below). Click OK to save.
Note: Message types that support HTML formatting will open the HTML Email editor. Raw HTML is not supported for Recall messages.

Variables are the text with brackets which pull information directly from the database. For example, the message might look like this: "John, you are due for your regular dental check-up on 01/12/2015."

Available variables:

[NameF]: Patient first name only.

[FamilyList]: List first name and recall due date of all family members (if Group Families is selected).

[DueDate]: Date the recall is due.

[URL]: (Web Sched only) The unique link the patient will click to schedule their appointment.

[ClinicName]: Clinic name (patient's default clinic).

[ClinicPhone]: Clinic phone number.

[PracticeName]: Practice name.

[PracticePhone]: Practice phone.

[OfficePhone]: Uses clinic phone number if available, otherwise inserts practice phone.

**Recall Status Options**
The status options determine which recall status is automatically applied when a recall reminder is sent. Customize options in [Definitions: Recall / Unsched Status](887).

**Status for mailed recall**: The status applied when a recall postcard is printed.

**Status for emailed recall**: The status applied when a recall reminder is emailed.

**Status for texted recall**: The status applied when a recall reminder is sent via text message using Web Sched Recall.

**Status for emailed and texted recall**: The status applied when a recall reminder is emailed and texted using Web Sched Recall.

**Recall List Defaults**
The following options affect what shows in the recall list by default.

**Types to show in recall list**: Highlight the Recall Types(635) to send recall reminders for. To highlight multiple types, click and drag or press ctrl while clicking each type. The prophy type covers both adult and child prophies.

Select the Recall List Default View filter and sort options.

**Group Families**: Determines the default setting of the Group Families box. When checked, family members are grouped together.

**Days Past**: Determines the default Start Date. The farther back you go, the fewer patients who will slip through the cracks. If using Web Sched Recall it cannot be blank.

**Days Future**: Determines the default End Date. Leave blank to include all future recalls. This value may be left blank for Web Sched Recall.

Select one of the exclude options to exclude certain patients from the recall list.

**Exclude from list if recall scheduled**: Do not include patients who have a scheduled recall appointment.

**Exclude from list if any future appt**: Do not include patients who have any scheduled appointment.
Set the reminder intervals to **Also show in list if # of days since** the patient's last reminder. Each patient will first show up on the list when they are due for recall. Once a reminder (Recall Commlog(1654) type) is sent, they will disappear from the list until they are due for their next reminder.

**Initial Reminder:** The number of days from the first reminder until the second reminder is triggered (e.g. 90 days from first reminder). This cannot be zero if using Web Sched Recall.

**Second (or more) Reminder:** The number of days from the second reminder until the third and subsequent reminders are triggered (e.g. 182 days from the second reminder). This cannot be zero if using Web Sched Recall.

**Max # of Reminders:** The maximum number of reminders before a patient is removed from the list. Leave the box empty to set no maximum.

Example: Setting this to three will include patients in the list until a fourth reminder is sent.

**Reminder Postcard Options**
Select the postcard print options (also affects printing of Confirmation List(35) postcards).

**Postcards per sheet (1, 3, or 4):** The number of postcards that print per page.

**Show return address:** Check the box to print the Practice(931) return address.

**Adjust Postcard Position in Inches:** Change the offset when printing.

**Reminder Email Options**
Select when an email reminder is sent (also affects confirmation list email reminders).

**Has Email Address:** Email will be the default Contact method with a patient has an email address entered (Edit Patient Information(62)) and no other preferred method is selected for recall.

**Email is preferred contact method:** Email will be a patient's default Contact method only when Email is the preferred confirmation or recall method.

**Recall Types**
Set recall appointment length, due date, and procedures in Recall Types.

In the **Main Menu**(592), click Setup, Appointments, Recall Types.

![Recall Types](image)

Every patient is assigned an exam and prophy recall, but can be set to perio as needed. Other custom types may be added. Each type is given an appointment length, recall interval, and procedures to be scheduled. Assign procedures that trigger the recall appointment, so every time these procedures are set complete, the patient's next recall appointment due date is generated. The patient will then appear in the **Recall List**(27) and when scheduled, the appointment will automatically treatment plan and attach the recall types' procedures.

**Note:** To reset all Recall Types back to default, use the Recall Types option in **Procedure Code Tools**(1198).

A patient's recall type(s), along with due dates, scheduled dates, and recall status shows in the upper right of the **Family**
Module(59), Recall(140) grid. There you may also customize the patient's recall interval, change the prophy recall to perio, delete/disable a patient's recall type, or add custom types from the Recall grid.

Add / Edit Recall Types
The default recall types are Prophy, Child Prophy, and Perio and these Special Types are required for recall to function. To add or edit recall types, from the Recall Types window, double-click an existing type to edit or click Add to create a new type. Update the information and settings in the Edit Recall Type window.

Description: Enter the identifying name.

Special Type: Select whether this recall type is Prophy, Child Prophy, or Perio. Only one of each type may be assigned to a recall. For custom recall types select None. The web sched feature only sends notifications for recalls assigned a special type.
- Prophy and Perio: Primary recall types and are mutually exclusive. The triggers for Prophy and Perio cross over and act as triggers for both types.
- Child Prophy: Only used to determine when, based on age, child procedures are attached to the recall appointment. Patients are still set to Prophy or Perio for recall but if the patient meets the age criteria, child recall procedures are attached.
**Age Limit:** (child prophy setting only) Enter the age limit that determines child procedures versus adult procedures. For example, if 12 is the age limit, patients 11 and under will have the Child Prophy procedures attached to their appointment instead of the Prophy procedures.

![Child Prophy](Image)

**Append to Special:** Determines whether this recall type is automatically scheduled with special type recalls.
- **Checked:** Automatically include this recall type when scheduling a special type recall, if it is also due. For example, to automatically add 4BW to a Prophy recall that is due, check the box for the 4BW recall type.
- **Unchecked:** Do not include this recall type with special type recalls when they are both due. For example, a recall type for a follow-up endo exam might have this box unchecked so it is not automatically added to a Prophy recall that is due.

**Procedures that trigger this recall type:** Click Add to select the procedures that trigger the recall. To delete a procedure, select a procedure and click Remove. When a patient has one of these procedures completed, the next recall appointment due date is triggered.

**Default Interval:** Determines the length of time between each recall appointment and calculates the recall due date. A common prophy interval is 6 months plus 1 day so that six month recalls are not accidentally scheduled too early.

**Time Pattern:** Create the time pattern for providers and assistants to determine the length of the appointment. Use slashes / for assistant time and X for provider time. Each character equals the time increment set in the Appointment module (see Appointment View Setup(621)). For example, if time increment is 10 minutes, //XX/ = 20 minutes of non-provider time, 20 minutes of provider time, 10 minutes non-provider time (50 minutes total appointment time).

**Procedures on Appointment:** Click Add to select procedures that will be attached to scheduled recall appointments. To delete a procedure, select a procedure and click Remove.

When finished, click **Sync** to apply the changes to patients with the recall type, or with a trigger procedure completed. For patients with manual edits to their recall interval, the Sync will not change the manual edits but their due date may be recalculated. If the updates are not synced, new or changed recall types will only affect new completed procedures.

**Family Module Preferences**

In the **Main Menu**(592), click Setup, Family / Insurance, Family Preferences.
Alternatively, click Setup, Module Preferences(927), Family tab.

Here you can set default options and settings for the Family Module(59).

**InsPlan option at bottom, 'Change Plan for all subscribers', is default:** Normally checked. Determines the default setting for the Change Plan for all subscribers radio button on the Insurance Plan(81).
- Checked: The radio button will default to checked, and changes to an insurance plan will apply to all subscribers.
- Unchecked: The radio button will default to unchecked and changes to an insurance plan will spawn a new plan.

**Default new insurance plans to PPO Percentage plan type:** Sets the default Plan Type when you create a new insurance plan.
- Checked: The default is PPO percentage. Useful for offices that see mostly PPO Insurance Plan(114).
- Unchecked: The default plan type is category percentage (Category Percentage Insurance Plan(118)).

**Use Blue Book:** Turn on/off the Blue Book(918) feature.

**Co-pay fee schedules treat blank entries as zero:** Set how blank entries in co-pay fee schedules are handled.
- Checked: Blank entries are treated as 0.
  - Example: UCR =$200, Contracted = $150, Write-off = 50, Copay = blank, Percentage = %100, Patient Portion = $0
- Unchecked: Blank entries are treated as 100% copay.
  - Example: UCR =$200, Contracted = $150, Write-off = 50, Copay = blank, Percentage = %100, Patient Portion = $150

**Fixed benefit fee schedules treat blank entries as zero:** Set how blank entries in fixed benefit fee schedules are handled.
- Checked: Blank entries are treated as 0.
  - Example: UCR =$200, PPO Fee = $150, Write-off = 50, Fixed = blank, Percentage = %100, Patient Portion = $150
- Unchecked: Blank entries are treated as 100% the PPO fee.
  - Example: UCR =$200, PPO Fee = $150, Write-off = 50, Fixed = blank, Percentage = %100, Patient Portion = $0
Insurance plans default to show UCR fee on claims: Set the default setting for the Claims show UCR fee, not billed fee box for category percentage plan types.
- Checked: The box defaults to checked.
- Unchecked: The box defaults to unchecked.

Insurance plans default to assignment of benefits: Set the default setting for the Assignments of Benefits check box when adding a new insurance plan.
- Checked: The box defaults to checked.
- Unchecked: The box defaults to unchecked.

Coordination of Benefits (COB) Rule: Set the default Coordination of Benefits (COB) (134) selected when adding a new insurance plan.

Text Msg OK status, treat ?? as No instead of Yes: Set the default behavior of ?? for Text OK on the Edit Patient Information (62) window. By default this box is checked.
- Checked: ?? will mean No and you will be unable to send text messages to this patient (text buttons will be disabled). This is the default.
- Unchecked: ?? acts as Yes for a patient's Text OK status. Text messages will be sent to the patient.

Allow Guarantor access to family health information in the Patient Portal: Determines whether guarantors will have access to other family member's health information in the Patient Portal Feature. This is a global setting.
- Checked: Guarantor will have portal access to health information for all family members. This is the default setting.
- Unchecked: Guarantor will only have portal access to their own health information.

Calculate secondary insurance PPO write-offs (not recommended, see manual): We do not recommend turning this preference on.
- Unchecked: Secondary insurance plan write-offs will not be calculated (recommended).
- Checked: Secondary insurance plans with a PPO percentage plan type will calculate write-offs when the primary insurance does not have a write-off (not recommended).

Show Google Maps in Patient Edit window: Determines whether the Show Maps button is visible on the Edit Patient Information window.
- Checked: The button shows. Click to open the patient's address in Google Maps.
- Unchecked: The button does not show.

Primary Provider defaults to 'Select Provider' in Patient Edit and Add Family windows: Determines the default setting for the Primary Provider when a new patient is added (Edit Patient Information and Add Family window).
- Checked: Primary provider dropdown defaults to Select Provider for new patients.
- Unchecked: When you click Add Pt on the Select Patient window, primary provider will default to default practice provider, or if using Clinics, the selected clinic's default provider. When you add a patient to an existing family (click Add in the Family module), the primary provider will default to the selected patient's primary provider.

Use the description for the charted procedure code on printed claims: Determines the procedure description used on printed claims when the charted procedure code description is different than the base procedure code description (e.g. when the description for D2999b [charted] is different than the description for D2999 [base]).
- Unchecked: The base procedure code's description is used.
- Checked: The charted procedure code's description is used.

This preference will not affect alternate or medical codes.
Require error code when adding custom claim tracking status: Determines whether or not an error code must be selected when a custom Edit Claim - Status History Tab (219) is selected.
- Unchecked: A claim tracking status can be added to a claim without selecting an error code.
- Checked: An error code must be selected when a claim tracking status is added to a claim.

New patient primary insurance plan sets patient billing type: Affects the billing type assigned to new patients. Customize options in Definitions: Billing Types (850).
- Unchecked: Billing type is assigned on the Edit Patient Information window.
- Checked: When a billing type is assigned to a newly created primary insurance plan, the patient’s billing type on the Edit Patient Information window will change to match the insurance plan’s billing type. Note that this only happens for new primary insurance plans; changing an insurance plan’s billing type will not change the patient’s billing type.

Show preferred referrals only in the Select Referral window by default: When adding a referral for a patient, show only referrals marked as preferred.

Autofill patient’s email address with the guarantor’s when adding many new patients: When adding a family using Add Many, autofill the guarantor’s email address into other family members.

Allow new patients to be added with an unassigned clinic: Only visible when Clinics (1505) is turned on.
- Checked: Allow staff to add a new patient who has a clinic of Unassigned.
- Unchecked: Require staff to assign a clinic when adding a new patient.

Ins plan with exclusions use UCR fee (can be overridden by plan): For use with PPO plans where certain excluded procedures are allowed to be billed using UCR fee rather than a negotiated rate. Exclusions are defined using an Other Benefits (94) exclusion rule, or for any benefit set to a 0% coverage level.
- Checked: Exclusions are billed at full UCR fee rather than negotiated rate with write-offs.
- Unchecked: Exclusions will be billed normally based on plan fee schedule.

Ins plans with exclusions mark as Do Not Bill Ins: Only for use if Exclusion Fee Rule is set to Use UCR Fee below, or in Insurance Plan (81), Other Ins Info tab.
- Checked: In addition to using UCR fee for procedure, exclusions will also be marked Do Not Bill Ins to prevent their inclusion on insurance claims.
- Unchecked: Exclusions will not be marked Do Not Bill Ins.

Super Family
Only an option if Super Family (143) is turned on.

Super family sorting strategy: Determines the order of super family names as they appear in the Family module. Refresh the Family module to view changes. The super head will always show at the top of the list regardless of sorting strategy.
- NameAsc: Sort by last names in ascending alphabetical order (A-Z).
- NameDesc: Sort by last names in descending alphabetical order (Z-A).
- PatNumAsc: Sort by patient numbers in ascending order. The patient with the lowest number will be first, followed by patients with higher numbers.
- PatNumDesc: Sort by patient numbers in descending order. The patient with the highest number will be first, followed by patients with lower numbers.

Allow syncing patient information to all super family members: Determines whether the Same for entire super family check box shows on the Edit Patient Information window for the head of the super family. This box allows you to make the address and phone information for all super family members match the address and phone information of the super head.
- Checked: The check box will show on the Edit Patient Information window of the head of the super family.
- Unchecked: The check box will not show.

Copy super guarantor’s primary insurance to all new super family members: Determines whether or not the user is
prompted to copy the super head's primary insurance plan when adding a new family to a super family. Useful for patients in nursing home situations.

- Checked: When a new family is added to a super family, user will be prompted to copy the super head's primary insurance plan to all patients in the family. By default, the insurance plan will have a Relationship to Subscriber of self and use the patient's Medicaid ID as the Subscriber ID. If there is no Medicaid ID, user will be prompted to enter a subscriber ID.
- Unchecked: No prompt is given when a new family is added to a super family.

**New patient clones use super family instead of regular family**: Determines the family behavior for new Clone(145).

- Unchecked: New patient clones will inherit the family and super family of the original patient (old behavior).
- Checked: Place new patient clones in a new family, and, if no super family already exists for the original patient, create a new super family with the guarantor of the original patient as the super head and the clone as a super family member.

### Claim Forms

Printed claim forms are set up from the Claim Forms window.

In the Main Menu(592), click Setup, Family/Insurance, Claim Forms.

![Claim Forms](image)

This page only contains information about claim forms that are printed.

Also see:

- **HCFA 1500 Claim Form**(645): How fields in a printed 1500 claim form are populated.

Note: The information in a printed claim form does not affect what is sent in e-claims.
**Internal Claim Forms**: The original claim form templates that come with Open Dental. Can only be copied.

**Custom Claim Forms**: Claim forms that can be customized, duplicated, imported, exported, or deleted.

**Set a Default Claim Form for New Insurance Plans**
The default claim form determines the default claim form on the Insurance Plan when a new insurance plan is created.

Under Custom Claim Forms, highlight the claim form. Click **Set Default**. An X will appear in the Default column next to the Claim Form name.

**Reassign Claim Forms**
If a new claim form is replacing an existing one, you can easily assign the new claim form to all insurance plans that use the old form.

1. Import the new claim form (see Import Claim Forms below).
2. In the Custom Claim Forms list, highlight the old form.
3. Click the Reassign dropdown and select the new form.
4. Click **Reassign**. A message will appear indicating how many insurance plans are affected by the reassignment.

**Import Claim Forms**
To import most claim forms, you need two files: an XML file and the background image file (GIF or JPG). Some claim forms only require an XML file.

1. Save the XML file and the image file in your A to Z Folder.
2. On the Claim Forms window, click **Import**.
3. Select the XML file, then click **Open**.

The new form will appear last in the Custom Claim Forms list. Once imported, the XML file is no longer needed by Open Dental, and you may delete it from your A to Z folder.

**Export Claim Forms**
Claims forms are exported in XML format.

1. Under Custom Claim Forms, highlight the claim form.
2. Click **Export**.
3. Select the location to save the XML file, then click **Save**.

**Edit a Claim Form**
Advanced users only.

Note: We recommend contacting Open Dental support if you need to make changes, as changes may affect claim submission and payment.

Possible reasons to modify a claim form:
- Change the identifying name of the claim form.
- Remove the claim form as an option in various lists (hide).
- Set whether or not background claim form images print.
- Change the alignment when printing on a preprinted form.
- Modify fields on the claim form (not recommended).

To make changes to an existing claim form, double click the form in the Custom Claim Forms list. The left side of the window will show the items on the claim form. The right side of the window will have an edit panel.

**Description:** Name of the claim form

**Width and Height:** Dimensions of the claim form when printed. Edit width and height when claim form is not printed on standard 8.5x11 sized paper.

**Is Hidden:** Hide a claim form so it no longer shows as an option in various drop downs.

**Print Images:** Set whether or not background images print.
- **Checked:** Print background claim image.
- **Unchecked:** Do not print the image (e.g. when printing on a preprinted form such as [Denti-Cal](660)).

**Offset X** and **Offset Y**: Change the alignment of the form when printing on a preprinted form. Values can be positive or negative and will shift all elements on the page by the given number of pixels in hundredths of an inch.

![Claim Form edit](image-url)
**Add a Claim Form**

You can add your own claim form from scratch, but it is very involved and takes a lot of time.

**Step 1: Prepare a background image.**
1. Scan a paper form at a high resolution.
2. In an image editing program (e.g. Photoshop), increase the contrast to make the black lines look blacker and the white areas whiter. Also erase any black flecks that remain. Resample the image to about 250 dpi, 8 bit b/w palleted.
3. Save the image in the A to Z folder as a GIF or JPG.

**Hint:** On the edit window, GIF image size can be easily adjusted by changing the width and height, but JPG image size cannot be changed. If you save as a JPG, set the compression and smoothing for as small a file size as possible without losing detail, somewhere between 200 and 500 Kb. The larger it is, the longer it will take to print.

**Step 2: Create a new blank claim form.**
1. On the Claim Form window, click Add to open the edit window.

**Step 3: Add the background image.**
1. In the edit panel, click Add then enter the background Image File Name.
2. Do some trial printing to make sure it's sized right and is positioned on the page so that it won't get cut off on one side. If using a GIF, you can adjust size by entering Width and Height. You may also have to adjust the xPos or yPos (not the offsets).

**Step 4: Add more items as needed.**
1. Click Add, then select the field name to add, then click OK.
2. Move items by clicking and dragging or by using the arrow keys.
   - To make the movement larger press Shift while pressing an arrow key.
   - To select groups of items to move as a unit, press Ctrl while clicking. When you have groups selected, any change you make in the four text boxes at the bottom will apply to all items in the group.

**Step 5: Click OK to save the form.**

**Hints:**
- The dollar amount fields are right justified, so the x position will function differently (for now, click to the right of an amount field to highlight it).
- Be careful not to accidentally drag when highlighting items, especially groups.
- Set the width or height to zero to get rid of the surrounding rectangle and to not restrict the area of printing.
- The screen may flicker as you drag.

**Delete a Claim Form**

You can delete a custom claim form as long as it is not being used by any insurance plans. Highlight the claim form, then click Delete.

**ADA 2012 and 2018 Claim Forms**

Below is an explanation of how each field on the printed ADA 2012, 2018, and 2019 Claim Forms (641) are populated.

- **Note:** The requirements for e-claims are different than the requirements for paper claims. Printing a claim does not represent what is sent in an e-claim. Likewise information sent in an e-claim does not necessarily print on a paper claim.
- The 2012 and 2018/2019 claims forms are nearly identical. The few changes are noted in their respective fields.

This table has been omitted.
HCFA 1500 Claim Form

Below is an explanation of how each field on the printed HCFA 1500 Claim Form (also known as CMS 1500) is populated for medical claims. Also see Medical Insurance(128). If a cell is blank, then the information is not automatically populated from the database.

Note: The requirements for e-claims are different than the requirements for paper claims. Printing a claim does not represent what is sent in an e-claim. Likewise information sent in an e-claim does not necessarily print on a paper claim.

This table has been ommitted.

Clearinghouses

In the MainMenu(592), click Setup, Family/Insurance, Clearinghouses.

If sending e-claims to a clearinghouse, you must first set up the clearinghouse.

Clearinghouses are listed alphabetically. If clinics is turned on, you can override some information by clinic (e.g. login credentials, export path). See Clearinghouse Clinic Setup(647). To view a clinic's Export Path overrides for all clearinghouses listed on the E-Claims window, select the clinic in the upper right.

To enter clearinghouse or direct carrier settings, double click the clearinghouse.

Add: Add a clearinghouse that isn't listed

Set a Default Dental, Medical, Eligibility Clearinghouse
Dental default: Single click on a clearinghouse, then click Dental.

Medical default: Single click on a clearinghouse, then click Medical.

Eligibility requests: Single click on a clearinghouse, then click Eligibility.

Note: If no eligibility default is set, the default for eligibility will be the chosen dental default. If no eligibility default is set and there is no dental default, the eligibility default will be the chosen medical default.

**Automatic Report Settings**

The settings below affect the automatic download of clearinghouse reports (e.g. ERAs, acknowledgment reports, text reports). Once a report is downloaded and processed, the information becomes part of the database and is accessible from any computer.

**Receive Reports by Service:** Determines the method used to receive reports.

- **Unchecked:** The computer specified will receive the reports. This is the original method used by Open Dental.
- **Checked (recommended):** Receive reports using the OpenDentalService.
  - On the server (or the computer that OpenDentalService is installed), check Service Manager(1412) to make sure the OpenDentalService is installed and running.
  - On the server, verify that you have a valid Report Path specified and 'Download ERAs' selected on the Edit Clearinghouse(656) window.

**Computer to Receive Reports Automatically:** Specify one computer which will download reports automatically from the clearinghouse server to the Report Path. Enter the IP address or computer/server name or click This Computer to use the computer you are currently on. If you enter a server name and leave Open Dental open on the server, the computer will automatically check the server for new reports according to the interval. If this field is blank, this feature is disabled.

**Receive at an Interval:** Set a time interval, in minutes, to automatically check the clearinghouse server and download new reports. Only values between 5 and 60 are allowed. 30 is the default.

**Receive at a set time:** Set a specific time to check the clearinghouse server and download new reports. Time will auto correct itself to valid format (e.g. 1:00 AM)

Note: Only some clearinghouses currently support automatic download of reports:

- ClaimConnect E-Claims(656)
- Denti-Cal(660)
- Electronic Dental Services(666)

**Individual Clearinghouses**

There are a number of Clearinghouses integrated with Open Dental to send Claims electronically. Users should first sign up with their selected clearinghouse, then set up the clearinghouse in Open Dental.

Clearinghouses differ greatly in size, infrastructure, and business model. Some are small and tend to serve a local geographic area or focus on customer service. Some are actively pursuing more direct connections with payors. Some clearinghouses are more accurately described as aggregators, having a direct connection to only a few payors and sending the bulk of their claims to another clearinghouse.

**Recommended Clearinghouses:**

- ClaimConnect E-Claims(656): Should be used if you want to use electronic attachments, electronic eligibility, or electronic billing (statements).
- Electronic Dental Services(666)

Additional clearinghouses and aggregators that are known to work well with Open Dental.
• **Apex** (652)
• **ANS E-Claims** (653)
• **ClaimX E-Claims** (659)
• **EMS E-Claims** (668)
• **Etactics** (669)
• **Inmediata E-Claims** (651)
• **Lindsay Technical Consultants E-Claims** (670)
• **Tesla E-Claims** (677)
• **Office Ally E-Claims** (671)
• **Post-n-Track E-Claims** (672)
• **RAMQ E-Claims** (673)
• **RECS E-Claims** (674)
• **TesiaBridge E-Claims** (679)

**Canada:**
- **ITRANS**
- **Claimstream**

**Other:** These are clearinghouses or aggregators that we have had significant complaints about over many years and are not interested in supporting. Do not use them.
- **Renaissance E-Claims** (675) (Do not use!)

### Direct Connections to Payors

Most payors prefer to use clearinghouses so they do not have to maintain direct connections with thousands of dental offices. However, some do offer direct connections. To use Open Dental for direct submission, there is work involved including: contact the payor, get their implementation guide, set up a partnership agreement, test, and finally upload claims. We do not provide implementation details and leave it up to individual offices. But it can still be useful for very large volume offices. The X-12 files will typically need to be manually uploaded to the carrier because there is no standard for transport.
- **BCBS Georgia E-Claims** (654)
- **BCBS Nebraska E-Claims** (655)
- **Colorado Medicaid E-Claims** (650)
- **Denti-Cal** (660)
- **Washington Medicaid E-Claims** (679)

The carriers below are also known to accept X-12 claims, but we have not had time to do any testing with them yet. Remember that we have no time line for this functionality and it might never even happen.
- **ACS** - Handles claims for Medicaid of Georgia and a few other states. Testing phase seems to be long.
- **Medicaid of NJ** - Could take a few months since they require certification
- **Medicaid of TX**

### Troubleshooting

For troubleshooting, see **Clearinghouse Error Messages** (500).

For more technical information about what is sent in e-claims, see **E-Claim Complexities** (496).

### Clearinghouse Clinic Setup

When using clinics, you can set different clearinghouse settings for each clinic.

In the **Main Menu** (592), click Setup, Family/Insurance, **Clearinghouses** (645).
When sending claims for Clinics(1505), the clinic-level overrides will be used instead of default settings. Default dental or medical clearinghouses will remain the same for all clinics.

Double-click the clearinghouse row to open the Edit Clearinghouse or Direct Carrier window.
Settings that can be set for each clinic are highlighted above. All other options are only enabled when the Unassigned/Default clinic is selected (upper right corner).

First enter settings for the clinic Unassigned/Default. These settings will be used by all clinics if no clinic-level overrides are entered.
- Select the clinic Unassigned/Default in the upper right
- Enter the settings. Refer to Clearinghouses (645) for a list of clearinghouses and direct carriers and link to their general settings.

Next enter clinic-level overrides. These settings will override Unassigned/Default information when sending claims for this clinic.
- Select the clinic.
- Enter the credentials as needed. You can enter Tax ID number, Name, Telephone Number, Login ID, Password, Claim Export Path, Report Path and Launch Client Program (.exe).
- Enable or disable Allow sending attachments and Save DXC Attachments to Image Module as needed.
- When finished with one clinic, select another clinic and enter its information.

Click OK to save all settings for all clinics. If you click Cancel, any changes made since the window was opened will be lost.
- Note: For details on how clinic assignment restricts user access in Open Dental, see User Edit (1109).
- If the currently logged on user is restricted by clinic, only the clinic they have access to will show in the Clinic dropdown.
If Unassigned/Default credentials match other clinic settings, and Unassigned/Default credentials are modified, the edits will affect the other clinics as well. To unlink a clinic from Unassigned/Default, simply change the clinic’s credentials. Then any changes made to Unassigned/Default will no longer affect the clinic.

Colorado Medicaid E-Claims
In the **Main Menu** (592), click Setup, Family/Insurance, **Clearinghouses** (645). Click Add.

![Colorado Medicaid E-Claims Setup](image)

Colorado Medicaid is an E-Claims Direct Carrier. Website: [http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1197364127336](http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1197364127336)

Set up using the above screenshot as a reference.

**Tax ID Number**: Enter the Trading Partner ID in the Tax ID Number field. Colorado Medicaid assigns the provider a Trading Partner ID once the provider is enrolled in Colorado Medicaid EDI. To locate the ID, log in to the Colorado Medicaid web portal at [https://sp0.hcpf.state.co.us/Mercury/MainMenu.aspx](https://sp0.hcpf.state.co.us/Mercury/MainMenu.aspx). The Trading Partner ID is displayed in the upper left corner.

For all Colorado Medicaid insurance plans, set the Filing Code to *Medicaid* on the **Insurance Plan** (81).

For all Colorado Medicaid claims that will be submitted electronically, the carrier associated with the insurance plan must have a carrier name of *CO Medicaid*. 
Send the claim. A new file will be generated in the clearinghouse export folder. The claim has not been sent to Colorado Medicaid at this point.

To finish sending, you must manually send the file over dial-up modem. The phone number to send to, as well as the login information for the dial-up session, can be found on the welcome letter sent to the provider from Colorado Medicaid.

Inmediata E-Claims
In the Main Menu, click Setup, Family/Insurance, Clearinghouses. Double click on Inmediata Health Group Corp.

You can visit their website at www.inmediata.com for more information about their services.

Set up as above, then click OK to save.

Technical Details
You will be using the IMPlug software provided by Inmediata to securely upload the claim files created by Open Dental. In the IMPlug - Configuration window, click the Integration Settings tab and fill it out like below. You will need to create the Reports folder and the Claims folder in the process.
You do not need to put anything in the Outbound History box because Open Dental already keeps a history in Claims\Archive.

**Electronic EOBS (ERA 835)**
Import of ERAs (568) is fairly automated. The Inmediata Inbound path should be set the same as the Report Path on the Edit Clearinghouse window. Then the 835s should import automatically each time a claim is sent, or manually when Get Reports is clicked on the Insurance Claims window.

**Apex**
In the Main Menu (592), click Setup, Family/Insurance, Clearinghouses (645). Double click on Apex.
Apex is an E-Claims clearinghouse. Contact Apex for additional required steps when sending claims electronically using Apex. Apex website:

Note: Please use Open Dental version 12.4.24 or later.

If claims are sent as a batch to Apex, preauthorizations and claims must be sent separately (Send Claims(489)). If sent together, Apex will merge the data and reject the preauthorizations for having a date of service.

**ANS E-Claims**

In Clearinghouses(645), click Add or double-click to edit.
ANS is a re-brand of RECS E-Claims(674) clearinghouse.

Set up as shown above, then click OK to save.

**BCBS Georgia E-Claims**

In the Main Menu(592), click Setup, Family/Insurance, Clearinghouses(645). Double click on BCBS GA.
BCBS of Georgia is a E-Claims Direct Carrier. Website: [http://www.bcbsga.com/home-providers.html](http://www.bcbsga.com/home-providers.html).

**BCBS Nebraska E-Claims**

In the [Main Menu](592), click Setup, Family/Insurance, [Clearinghouses](645). Click Add.
BCBS Nebraska is an E-Claims Direct Carrier. See [http://www.bcbsneprovider.com/NEBLUEconnect/contacts.asp](http://www.bcbsneprovider.com/NEBLUEconnect/contacts.asp) for contact information.

Enter the clearinghouse information:
1. **Description, Clearinghouse ID, and GS03**: Enter NEBLUECONNECT.
2. **Claim Export Path**: Enter the path where claims will be saved when they get created by Open Dental. Select to create this folder when you save these settings.
3. **Comm Bridge**: Select None.
4. **Payors**: Add payor 00760.

Providers must have supplemental provider ID added for BlueShield and Electronic ID 00760. Use the provider ID that they assigned you. **Provider (1255)**

Upload your claims to BCBS using their website.

**ClaimConnect E-Claims**

In the [Main Menu](#)(592), click Setup, Family/Insurance, [Clearinghouses](#)(645). Double-click on ClaimConnect.
Visit [www.dentalxchange.com](http://www.dentalxchange.com) or contact DentalXChange at 800.576.6412 Ext 455 to learn more about their services and pricing.

**Set up in Open Dental**

**Login ID and Password:**

Enter your DentalXchange account credentials. 

Note: If **Clinics** (1505) are enabled it is possible to save unique login credentials for different Clinics. Use the Clinic dropdown in the top-right to switch between each and enter a different Login ID and Password as required.

**Use Claim Export Path:**
- **Checked:** Save 837 files sent with e-claims to the Claim Export Path.
- **Unchecked:** Block saving 837 files sent with e-claims to the Claim Export Path.

**ERA Options:**
- **Report Path:** Enter path where downloaded ERAs will be stored.
- **Do Not Download ERAs:** Do not automatically download ERAs (568).
- **Download ERAs:** Automatically download ERAs to the Report Path.
According to ClaimConnect, the advantages are:

- HIPAA compliant X12 format.
- Submits directly from Open Dental software via secure, HTTPS Internet protocol. No third party program to download and install.
- ClaimConnect offers direct connections to most major insurance companies meaning less “hops” in between you and the Payor and faster payments.
- ClaimConnect is the only service that offers real-time claim processing for MetLife claims. You get an Estimate of Benefits back within moments of the claim submission.
- Online claim management screens that allow you to view, track, edit and even resubmit claims with a few mouse clicks and keystrokes.
- Other HIPAA compliant real-time services available include:
  - Eligibility and Plan Benefit information for selected Payors.
  - Claim Status Inquiry for selected Payors.
- 30 Day Satisfaction Guarantee

Register with ClaimConnect

2. Create a new account or edit your existing account.
3. Select Open Dental as your Practice Management Software.
4. Choose the services you are interested in.

- To use ClaimConnect for electronic eligibility and benefits, see Electronic Eligibility and Benefits(108).
- To use DentalXChange for patient credit checks, see DentalXChange Patient Credit Score Service(971).
- To use DentalXChange for attachments, see below.

Attachments

DentalXChange Attachment(215) Service is an additional paid service for sending Electronic Attachments(227).
1. Sign up with DentalXChange. Contact DentalXChange for pricing and account setup.
2. Check Allow sending attachments in this setup window. If using clinics, this option can be enabled or disabled on a per clinic basis using the dropdown at the top-right.
3. To allow saving attachments, check Save DXC Attachments to Images Module. If checked, create an Image Category in Definitions: Image Categories(869). When checked, attachments will be saved to the Images Module when attachments are created.

Other Services

The password above applies to other services from DentalXChange:
- When billing, see Electronic Billing(514).
- For credit card services, see PayConnect Window(168).
- If using electronic benefit remittance, see ERAs(568) and set up a Report Path.

Troubleshooting & Technical Details

DentalXChange sometimes uses payor ID 06126 as the default for insurance carriers that do not do e-claims.

The best troubleshooting approach to nearly any problem is to monitor the DentalXChange website. It will show you which claims were successfully submitted, which ones have errors, and so on. Use it regularly to stay on top of your claims.

When sending claims, receive 'authentication failed.authBadPwd' error.

This error is due to a bad password.
1. Go to the DentalXChange website and verify that the user can login.
2. Verify that the same password is entered for the clearinghouse in Open Dental.

Note: Passwords in ClaimConnect are case sensitive. Be sure to use the correct capitalization when entering the ClaimConnect password in Open Dental. Special characters (%, !, $, etc) are not allowed in Open Dental.
Soap Exception
You may receive a “Soap Exception” from Claim Connect when attempting to send e-claims. This is almost always because the Electronic ID entered for the carrier is wrong. Go to the payer list on the DentalXChange website: [http://www.dentalxchange.com/x/payerlist.jsp](http://www.dentalxchange.com/x/payerlist.jsp) and look up the carrier to verify the Electronic ID shown in the Edit Insurance Plan window. Fix the ID, and resend. If the ID was correct, then you might need to enroll with the carrier for electronic submission. Enrollment forms may be found here: [http://www.dentalxchange.com/x/enrollmentpayers.jsp](http://www.dentalxchange.com/x/enrollmentpayers.jsp).

Claims Not Sending. You send claims. There are no errors, but nothing gets sent. The claim files are still sitting in the out folder such as, or whatever your setting is in the window above.
The most likely explanation is that your Comm Bridge in the window above is set to None instead of ClaimConnect.

Uploads Fail
After a failed upload, the next time that a user tries to send a claim, there is a warning, "A previous batch submission was found in an incomplete state." Resubmit the batch in question as well as the subsequent failed batch. Also, check the ClaimConnect website to make sure all claims went through. This can be a particularly annoying problem because the user who gets the error message might click through it without reading it. There will then be no further warning, and the office may not realize that the batch failed until they start following up on aging claims a few weeks later. So, if you get a warning of some sort, start checking the DentalXChange website to verify that recent batches went through.

Invalid authentication request.authNoGroupUserFound.
This may be due to an interface change at ClaimConnect that requires an action on your part. You are required to either check package requirements or view must read messages and general announcements prior to logging in and sending claims. Please contact DentalXChange.

Error retrieving. Era request unsuccessful. Error message received directly from ClaimConnect: 150. Service Not Contracted.
This means you are not signed up for the ERA download service with ClaimConnect. You have two options: 1. To enable the service, contact ClaimConnect. 2. To stop the error message (and not enable the service), update to version 16.1.14 or greater.

ClaimX E-Claims
In the [Main Menu](#)(592), click Setup, Family/Insurance, [Clearinghouses](#)(645). Double-click on ClaimX.

ClaimX also offers Electronic Billing (514).

Set up as above, then click OK to save.

**Creating a Claim**

For the ClaimX client program to recognize a claim, it must have a Claim Status of *Waiting to Send*.

- When you create a claim, just click OK; do not click Send. This will mark the claim *Waiting to Send* and it will show in the ClaimX client program.
- To re-submit a claim, change the Claim Status to *Waiting to Send*; do not click Resend.

**Denti-Cal**

Offices may submit claims directly to Denti-Cal using the process outlined below.

Most Denti-Cal users submit claims to a clearinghouse, which then submits to Denti-Cal. Open Dental users have submitted claims to Denti-Cal in this manner for many years.

- EDI Support Phone: (916) 853-7373. Ask for Denti-Cal EDI Support when you’ve reached an operator.
  - EDI Support Email: denti-caledi@delta.org
ClaimConnect Support Phone: (800) 576-6412 Ext 455. Setup as usual and contact ClaimConnect support to register your intent to submit to Denti-Cal.
  o ClaimConnect website: http://www.dentalxchange.com/

To submit claims to Denti-Cal, you can print a paper Claim Form, or submit E-Claims(645).

If printing forms, here are the downloads for the 2008 Denti-Cal claimform:
  • DC-217.gif - background image for all versions.
  • Dentical-DC-217.xml - use for versions 12.3.2 and earlier.
  • Dentical-DC-217_v12_3_3.xml - use for versions 12.3.3 and greater.
  • Dentical-DC-217_v17.2.1.xml - use for versions 17.2.1 and greater.

For detailed steps on importing these files into Open Dental, see Claim Forms(641).
  • Note: Occasionally (like in June-October of 2019) Denti-Cal requires communication testing when they make changes to their system.
  • This generally does not involve Open Dental. You should contact Denti-Cal to schedule testing.
  • If any bugs are discovered when testing, then please contact Open Dental.

In one example, after contacting Denti-Cal, the office needed to generate a claim batch to file and then upload it manually into the Web Portal to verify structural integrity of the X12 output. If the office needed to use a different server address for SFTP for any reason, they could have gone ahead and entered it manually for testing.

Submitting Claims
Larger offices have always wanted to submit directly to Denti-Cal, because there is a fee per claim when using a clearinghouse. The Open Dental X12 file format is certified by Denti-Cal, however each dental office that wishes to submit directly must also go through their own certification testing with Denti-Cal. If you wish to submit e-claims directly to Denti-Cal, you must use Open Dental version 13.1.43 or later. During the testing phase, you can still use your existing clearinghouse (e.g. ClaimConnect) to submit claims.

The general test certification steps are as follows:
1. Fill out the Provider Service Office Electronic Data Interchange (OSF) form, EDI Enrollment Application, and Electronic Remittance Advice (ERA) form and submit to Denti-Cal.
2. Conduct a preliminary test with Denti-Cal. Submit one 837D claim transaction to Denti-Cal. Once successful, Denti-Cal’s EDI Support will request a formal project from the State. After obtaining approval from the State, Denti-Cal will provide Tumbleweed instructions (a secure email).
3. Denti-Cal will issue a Login ID (Remote ID) and password when a provider enters the full testing phase (step 4). Use this information to set up the Denti-Cal clearinghouse.
4. Complete the full testing phase by submitting test cases for certification.
5. Wait for test verification.

1: Fill out the Provider Service Office Electronic Data Interchange OSF
Providers currently enrolled to submit electronically must update EDI enrollment to that of a direct submitter by completing the Provider Service Office Electronic Data Interchange Option Selection Form (OSF). There is also an additional ERA Enrollment Form to address the 835 transaction. These forms can be found on the Denti-Cal website.

On the OSF, there is a section named EDI INPUT/OUTPUT OPTIONS. It should be filled out as follows.
Submit the form to Denti-Cal.

If a Service Office Number must be sent in order to supplement an NPI, then enter that number at the bottom of the Provider (1255), with a type of SiteNumber. That number will be sent in loop 2010BB with a qualifier of LU.

2: Conduct a Preliminary Test with Denti-Cal

Denti-Cal will request that you submit one 837D claim transaction to Denti-Cal using Tumbleweed (a secure email).

1. In the Main Menu (592), click Setup, Family/Insurance, Clearinghouse, then double-click on Denti-Cal. Temporarily change the Comm Bridge setting to none. Clearinghouses (645)
2. Create the claim in Open Dental.
3. Click Send to send the claim file to the Claim Export Path set on the Edit Clearinghouse window (typically C:\Denti-Cal\).
4. Send the file to Denti-Cal as requested.

Once this test is successful, Denti-Cal will request a formal project from the State.

- Note: If Denti-Cal is your primary clearinghouse, set Denti-Cal as the default in the E-Claims window.
- If Denti-Cal is not your primary clearinghouse, enter each Insurance Plan's Payor ID in the Edit Clearinghouse window.

3: Set up the Denti-Cal Clearinghouse

Once a provider enters the full testing phase (step 4), Denti-Cal will issue a Login ID (Remote ID) and password. Use this information to set up the Denti-Cal clearinghouse. The Remote ID starts with the letters DC. Any other letters in the Remote ID must be capitalized when entered into the clearinghouse setup window.

In the Main Menu, click Setup, Family/Insurance, Clearinghouse, then double-click on Denti-Cal. Enter the information below, using the Remote ID and password supplied by Denti-Cal. Make sure to change the Comm Bridge back to Denti-Cal.
Note: Anyone wishing to test Denti-Cal claims will need to set the ISA15 field in the clearinghouse setup to T to enable testing mode.

4: Submit Test Cases for Certification

For test cases, use data from real patients and real insurance plans to make testing easier. The claims used for testing should be fake claims, because they will not be adjudicated.

Manually enter two test patients into a blank Open Dental database as follows:

- **Patient 1:** One Denti-Cal insurance plan with real subscriber name and subscriber ID. No other insurance plans.
- **Patient 2:** Two insurance plans. The primary insurance plan must be a non Denti-Cal plan with fake subscriber name and fake subscriber ID of 123456789. The secondary plan must be a Denti-Cal plan with a real subscriber name and a real subscriber ID.

Create the following fake procedures and claims for certification testing. Once all claims are created, all test cases can be sent in a single test batch.

The following test cases were updated on 09/08/2015:

1. Representation of all document types as applicable:
   - Select patient 1
   - Claim
     - Create and complete one procedure: a D2161 with fee 230.
     - Create a claim for the D2161.
     - In the Edit Claim window, under the General tab, type the following Claim Note: “Claim test”
TAR (Preauthorization)
- Create a treatment planned procedure: a D0150 with fee 20.
- In the Treatment Plan module, select the D0150 and click the Preauthorization button to create a new Preauthorization claim.
- In the Edit Claim window, under the General tab, type the following Claim Note: "TAR test"

NOA for Payment
- Create and complete one procedure: a D2950 with fee 210.
- Create a claim for the D2950.
- In the Edit Claim window, under the Misc tab, set the Prior Authorization (rare) to ABCDEFGH.
- In the Edit Claim window, under the General tab, type the following Claim Note: "NOA test"

Claim Adjustment (Correction)
- Create and complete one procedure: a D1110 with fee 40.
- Create a claim for the D1110.
- In the Edit Claim window, under the Misc tab, set the Correction Type to Replacement and the Original Reference Num to "123456789".
- In the Edit Claim window, under the General tab, type the following Claim Note: "Claim Adjustment test".

2. Claim with x-rays and attachments.
   - Select patient 1.
   - Create and complete one procedure: a D6750 with fee 500 (Prosthesis Replacement set to initial).
   - Create a claim for the D6750.
   - In the Edit Claim window, under the Attachments tab, type "1" in the Radiographs textbox.
   - In the Edit Claim window, under the Attachments tab, set the Attachment ID Number to "NEA#1234567".
   - In the Edit Claim window, under the General tab, type the following Claim Note: "x-ray and other attachment test"

3. Claim with multiple dates of service.
   - Select patient 1.
   - Create and complete one procedure: a D0120 with fee 60.
   - Create and complete one procedure: a D1351 with fee 130.
   - Set the date for the D0120 to today's date, and set the date for the D1351 to yesterday's date.
   - Create a single claim with both procedures attached.
   - In the Edit Claim window, under the General tab, type the following Claim Note: "Multiple dates of service test"

4. Claim with multiple rendering providers.
   - Click Setup, Account. Check On e-claims, send treating provider info for each separate procedure.
   - Select patient 1.
   - Create and complete one procedure: a D0140 with fee 57.
   - Create and complete one procedure: a D0272 with fee 130.
   - Change the treating provider on the D0140 so it is different than the treating provider for the D0272 (based on NPI).
   - Create a single claim with both procedures attached.
   - In the Edit Claim window, under the General tab, type the following Claim Note: "Multiple rendering providers test"

5. At least one transaction that includes a service description.
   - Select patient 1.
   - Create and complete one procedure: a D0330 with fee 88.
   - Edit the D0330. In the bottom left of the Procedure Info window, type "test note" into the E-claim Note.
   - Create a claim for the D0330.
   - In the Edit Claim window, under the General tab, type the following Claim Note: "Service description test"

6. At least one transaction that includes a Share of Cost amount.
   - Select patient 1.
   - Create and complete one procedure: a D0270 with fee 100.
   - Create a claim for the D0270.
   - In the Edit Claim window, under the General tab, type the following Claim Note: "Share of Cost test"

7. At least one transaction that includes an Other Health Coverage amount.
   - Select patient 2.
   - Create and complete one procedure: a D1120 with fee 58.
   - Create a primary claim for the D1120.
     - Edit the claim and click the By Procedure button.
     - Enter an insurance payment amount of 18.
   - Create a secondary claim for the D1120. This is the claim which Denti-Cal will see. The share of cost in this example is 18.
   - In the Edit Claim window, under the General tab, type the following Claim Note: "Other Health Coverage test"
   - Only send the secondary Denti-Cal claim for testing purposes. The primary claim should not be sent.

8. At least one transaction reflecting a non-employment related accident.
   - Select patient 1.
o Create and complete one procedure: a D2140 with fee 135.
o Create a claim for the D2140.
o Edit the claim. In the General tab at the bottom, change the Accident Related dropdown to Other, set the Accident Date to today's date, set the Accident State to your state.
o In the Edit Claim window, under the General tab, type the following Claim Note: "Non employment-related accident test"

9. At least one transaction reflecting an employment-related accident.
o Select patient 1.
o Create and complete one procedure: a D2150 with fee 165.
o Create a claim for the D2150.
o Edit the claim. In the General tab at the bottom, change the Accident Related dropdown to Employment, set the Accident Date to today's date, set the Accident State to your state.
o In the Edit Claim window, under the General tab, type the following Claim Note: "Employment-related accident test"

10. One or more transactions that include:
o Select patient 1.
o Tooth code(s)
  § Create and complete one procedure: a D2940 with fee 90.
  § Create a claim for the D2940.
  § In the Edit Claim window, under the General tab, type the following Claim Note: "Tooth code test"
o Arch code(s)
  § Create and complete one procedure: a D5110 with fee 1130 (Prosthesis Replacement set to initial).
  § Create a claim for the D5110.
  § In the Edit Claim window, under the General tab, type the following Claim Note: "Arch code test"
o Quadrant code(s)
  § Create and complete one procedure: a D4341 with fee 220...
  § Create a claim for the D4341.
  § In the Edit Claim window, under the General tab, type the following Claim Note: "Quadrant code test"
o Surface code(s)
  § Create and complete one procedure: a D2160 with fee 210.
  § Create a claim for the D2160.
  § In the Edit Claim window, under the General tab, type the following Claim Note: "Surface code test"

11. According to Denti-Cal: "When a single NPI is registered with Denti-Cal for more than one service office, the NPI is considered non-subparted. If transactions for non-subparted NPIs will potentially be submitted, submit transactions for multiple service offices. Service office locations are identified using qualifier 'LU' in REF01 of Loop 2010BB." Open Dental does not currently handle sub-parted NPIs for Denti-Cal. If this feature is needed, please contact us.

12. According to Denti-Cal: "If services will potentially be rendered to recipients residing in SNF or ICF facilities, submit Service Facility information in Loop 2310C." To send the service facility information (site place of service, address and NPI), follow these steps.
1. Create a provider that is 'not a person' and for NPI enter the service facility's NPI.
2. Create a site (Site List(1272)) for the service facility and enter the following:
   § Assign the provider as the default Provider.
   § Set the default place of service to something other than office.
   § Enter the site's address.
3. For at least one procedure assign the site (Procedure - Misc Tab(315)).
4. Create a claim for the procedure and send it.
Note: For 5010 dental e-claims, the place of service on the claim cannot be 'office' and the site provider cannot be the same as the billing provider.

Notify Denti-Cal's EDI Support (denti-caledi@delta.org) that you intend to submit a batch of test claims. To send the test batch, in the Manage module, click Send Claims. Click the Send E-Claims dropdown, then select Denti-Cal.

5: Wait for Test Verification
Following review, EDI Support will let you know if there is anything wrong with the batch, or if additional test claims are needed. EDI Support will notify you when the batch meets their test requirements, then they will notify you when you have been cleared for live claims in the production environment.

Preauthorization DCN
DentiCal assigns a Document Control Number (DCN) to the original preauthorization submitted. When the claim associated with a preauth is submitted, DentiCal requires that the DCN be in 2300 REF(G1). This field is normally where we put the preauthorization string that the user can enter in the Claim Edit window. So the user has control of this field.
you can figure out what the DCN is by looking at the approval that was sent by DentiCal, then you can put that number into the PreAuth Number field in the Edit Claim window.

**Electronic Dental Services**

In the [Main Menu](592), click Setup, Family/Insurance, [Clearinghouses](645). Double-click on Electronic Dental Services.

Electronic Dental Services (EDS) is an E-Claims clearinghouse that offers a low cost service. You can visit their website at [www.edsedi.com](http://www.edsedi.com) or call them 800-482-3518. They will supply you with a program to install and help you set it up.

EDS also offers:
- Electronic billing: See [Billing Defaults](510) for electronic statement setup.
- ERA 835 download: See [ERAs](568).

Enter EDS details using the screenshot above as a guide:

**Comm Bridge:** When set to EDS, claims will be sent directly to the EDS clearinghouse. When set to *none*, claims will be sent to the Claim Export Path instead.

**Use Claim Export Path:** This is only an option when EDS is the Comm Bridge. Check the box save 837 files sent with e-claims to the Claim Export Path. Uncheck to block saving the files.
Do Not Download ERAs: This is only an option when EDS is the Comm Bridge. Do not automatically download ERAs (568).

Download ERAs: This is only an option when EDS is the Comm Bridge. Automatically download ERAs to the Report Path.

Change Healthcare Medical E-Claims
In the Main Menu (592), click Setup, Family/Insurance, Clearinghouses (645). Double-click on Emdeon Medical.

Change Healthcare (formerly Emdeon) is the only E-Claims clearinghouse currently available for Medical Insurance (128) e-claims.

For more information about Change Healthcare's services, visit their website at changehealthcare.com. To locate payor IDs for carriers that Emdeon/Change Healthcare Medical supports, visit https://access.emdeon.com/PayerLists/.

1. Fill out this registration form: Emdeon Enrollment Form
2. Within 3 to 5 business days of receipt, an Emdeon rep will contact you to deliver your ITS credentials (used in step 4), discuss payor agreement requirements, and review reporting and support tools you will be given access to.
3. In Show Features (806), enable Medical Insurance.
4. In Open Dental, set up the Emdeon Medical clearinghouse. Enter the user name and password provided by Emdeon, then click OK to save.
Electronic Attachments
Medical attachments cannot currently be sent through Open Dental. Most medical payors do not accept electronic attachments. However, it may be possible to send electronic attachments to a few select carriers with a third party application called NEA FastAttach/Vyne Medical. Emdeon Medical is directly integrated with FastAttach. Please call Emdeon Medical and FastAttach support lines for details.

ERA Automatic Downloads
Emdeon Medical supports automatic downloads of ERAs. Setup a Report Path, and select Download ERAs to enable in Open Dental. Contact Change Healthcare to enable this option for your account. See ERAs(568).

Viewing Status of Sent Claims
Log in to the Emdeon Vision online portal at https://access.emdeon.com/ to see the status of your sent claims. Contact Emdeon Medical for details.

Troubleshooting
Problem: When I submit e-claims, I get the error message “Medicare Assignment is required.”

Solution: There are two known reasons why this error can occur. Either the claims were submitted with an older version of Open Dental, or the Filing Code on the Insurance Plan(81) was not set to the proper Medicare option (the most common option is MedicarePartB).

Problem: I receive an error message in the Emdeon Vision online portal stating “Billing Provider Taxonomy Code: Required; Must be entered for Payer.”
Solution: The claim billing and treating provider must be the same for any claim sent to the insurance carrier in question. Most carriers do not require this extra step. However, in some states, Medicare and Medicaid sometimes have this extra requirement.

EMS E-Claims
In the Main Menu(592), click Setup, Family/Insurance, Clearinghouses(645). Double click on EMS.
Set up as above, then click OK to save.

**Etactics**
In the [Main Menu](592), click Setup, Family/Insurance, [Clearinghouses](645). Click Add.
Etactics is an E-Claims clearinghouse. Website at www.etacticsinc.com.

Set up as above, then click OK to save.

If using version 14.2 or earlier, do not change the Description. It must be ETACTICSINC.

Lindsay Technical Consultants E-Claims
In the Main Menu(592), click Setup, Family/Insurance, Clearinghouses(645). Click Add.
Lindsay Technical Consultants is an E-Claims clearinghouse. For more information about services offered, visit their website at [www.lindtech.com](http://www.lindtech.com).

Set up as above, then click OK to save.

**Office Ally E-Claims**

In the [Main Menu](592), click Setup, Family/Insurance, [Clearinghouses](645). Click Add.
Office Ally is an E-Claims Clearinghouse. Office Ally accepts medical and institutional claims in addition to dental claims. Visit their website at [www.officeally.com](http://www.officeally.com).

Please use Open Dental version 12.3.42 or greater, or 12.4.27 or greater.

Set up as above, then click OK to save.

Take note of the Claim Export Path since this is where claim files are saved. You will need to manually upload claim files to the Office Ally website.

### Post-n-Track E-Claims

In the [Main Menu](592), click Setup, Family/Insurance, [Clearinghouses](645). Double click on Post-n-Track.

Set up as above, then click OK to save.

**RAMQ E-Claims**

In the **Main Menu**(592), click Setup, Family/Insurance, **Clearinghouses**(645). Double click on RAMQ.
This bridge in Clearinghouses (645) is only partially complete as of version 17.1.

You can output claims to a file (claim export path).

Uploading files to the RAMQ servers is still in development.

**RECS E-Claims**

In the Menu (592), click Setup, Family/Insurance, Clearinghouses (645). Double click on RECS.
Call them at (888) 888-6504. They will supply you with a program to install, help you set it up, and supply you with a Login ID and password.

After that is done set up using above screenshot as a reference. Click OK to save.

**Renaissance E-Claims**

In the **Main Menu** (592), click Setup, Family/Insurance, **Clearinghouses** (645). Double-click on Renaissance.
Renaissance is an E-Claims clearinghouse solution that uses Remote Lite software. Website: [www.rss-llc.com](http://www.rss-llc.com).

Contact Renaissance to set up your account and install the RemoteLite program.

Note: Renaissance uses its own unique format for claims (not X-12). We do not recommend using a format that is not X-12 format. No validation is done on claims and not as much information can be sent. For example, Renaissance's unique format only allows sending information that can be printed on a claim form. X-12 format allows for 15 different places of service, but Renaissance only allows 4 particular places of service, which are Provider's Office, Hospital, ECF, and Other. Some insurance companies reject claims if the place of service is not properly set for specific procedure codes. Some offices choose to use Renaissance anyway. Please bear in mind that our support for Renaissance issues is minimal. We do not plan to add additional functionality to the current custom format. Renaissance has indicated that they eventually plan to switch to the standard X-12 format which will resolve these issues.

Set up using above screenshot as a reference, then click OK to save.

- If using Renaissance Version 5 or greater the Claim Export Path should be changed to `C:\Users\Public\RES\DOTR\upload\`.
- Update the Launch Client Program file path if needed. It should point to the location of the `RemoteLite.exe`.

**Claims**

See [Send Claims](489).

When you send a claim to Renaissance from Open Dental, the Remote Lite program will come up with a list of claims that have been created. Click the Send Claims Button at the bottom of the Remote Lite window.
If you see a claim that you don't actually want to send, you can highlight it and click the red X delete button in RemoteLite. Then go back to Open Dental and change the status of the claim back to *Waiting to Send*.

- **Note:** If you have more than 8 procedures on a claim, the claim will be rejected. Make sure to send two separate claims in that case, with some procedures on each claim.
- **Practice address must be on one line.** If address includes a suite or unit number, do not use the field for Address 2 in Practice Setup.

**Technical Details**

Renaissance only supports four places of service in their custom electronic claims format. Below are the Open Dental settings for place of service, and how they output to Renaissance. If you need to submit claims with a place of service not listed here, we recommend contacting Renaissance. This table has been ommitted.

All other Place of Service codes in Open Dental are not supported by Renaissance and will not output anything to the Renaissance claim.

**Tesia E-Claims**

In the [Main Menu](592), click Setup, Family/Insurance, [Clearinghouses](645). Double click on Tesia.
Tesia is an E-Claims clearinghouse. The information below may not be current or accurate. Please contact Tesia for updated information and installation.

Registration Tips: When signing up, pick one computer where you will be submitting from (usually front desk), and answer the question about the operating system as it pertains to that computer. The question about “submitting to all insurance carriers” should be answered yes. After that page, when you click submit, it might take 30 seconds for the PDF form to load up. When filling out the PDF, there will be some fields that cannot be filled in using the keyboard and mouse. That's OK. After you've filled out what you can, click the submit button at the bottom. It will automatically print the form. Fill out the remainder of the form (credit card info and signature) and fax it in.

If, for some reason, the above online method does not work, fill out this PDF instead: TesiaLink_OpenDental.pdf. Then, fax it to Tesia.

The program that uploads the claims to Tesia is called TesiaLink. Click here to install it: Tesialink_setup.exe. After it's installed, when you first try to run it, it will ask you for a registration number. Call Tesia at 1-800-724-7240 to obtain the registration number. This is also the phone number to use for future customer service if it is totally unrelated to Open Dental.

The installation program will have created a folder called C:\TesiaLink. There will also be two folders inside that one:

C:\TesiaLink\OUT - Open Dental sends claim files here. TesiaLink uploads them automatically.

C:\TesiaLink\IN - Response files coming back from Tesia show up here temporarily before Open Dental imports them.

After that is done set up using screenshot above as a reference.
When it's time to send e-claims, you will have to manually start the TesiaLink program first at C:\Program Files\TesiaLink\TesiaLink.exe or by using the installed shortcut on your desktop. Just leave it running in the background. It shows as an icon in the lower right notification area of your taskbar. Don't click on the icon, as there are no settings to change, and it will tend to malfunction if clicked on.

Check the TesiaLink connection status. It should say CONNECTED or IDLE. If DISCONNECTED, claims will not be sent, even though Open Dental may appear to be working. In the past, TesiaLink has been blocked by anti-virus programs, such as Microsoft Security Essentials, and should be added to the list of program exceptions.

**Reports**

At the top of the Insurance Claims window (see Send Claims(489)), Click the Reports button. Double click on each item to view and print. Then archive. There are three types of text reports that you will see:

- Summary by Provider: Usually comes back the next day after a batch submission.
- Summary by Insurance Co: Usually comes back the next day after a batch submission.
- Daily Insurance Correspondence: This report is different than the other two. It's a supplemental report. It contains responses from the insurance companies that come back days to a week later. The claims contained in this report will be from different submission dates. It provides additional helpful information, but should never be expected to contain all the claims from the other two reports. This report is typically sparse.

**TesiaBridge E-Claims**

TesiaBridge was an E-Claims clearinghouse(645) solution by Renaissance Electronic Services. It uses X-12 file format. It is no longer offered.

To set up this clearinghouse, contact Renaissance. Website: [www.res-ilc.com](http://www.res-ilc.com).

**Washington Medicaid E-Claims**

In the Main Menu(592), click Setup, Family/Insurance, Clearinghouses(645). Click Add, or double-click to edit.

Other Resources:
- Dental Provider Guide: http://hrsa.dshs.wa.gov/billing/dental-related_services.html
- HIPAA/EDI web page: http://hrsa.dshs.wa.gov/hipaa/index.htm

**Manually Upload Claims in X12 5010 format**

In the E-Claims window click **Add**. Set up the clearinghouse as shown above.

The Tax ID Number should be 9 digits. To find the Tax ID Number, log in to the ProviderOne web portal and locate the 7-digit ProviderOne ID at the top of the page, then tack two trailing zeros at the end to make it 9-digits.

Click **OK** to save.

In the Main Menu, click **Lists**, **Insurance Carriers** (1237) and add a new carrier using the information below.
MakesureALLWashingtonMedicaidinsuranceplansusetheWAStateHCAcarrier,andtheinsurancefilingcode
Medicaid(InsurancePlan(81)).

IntheManageModule(487),clickSendClaims.SelecttheclaimsforWashingtonMedicaidonly,thenclicktheSendE-
ClaimsdropdownandselectWashingtonMedicaidfromthelist.

Inafilebrowser,gotoC:\WashingtonMedicaid\.Changetheextensionsonthenewestfilesfromtxttodat.Olderfiles
shouldalreadyhaveadatextension,soitisoughtoeasytotellwhichfilesarenew.Youcanalsolookatthefiledateand
timeinformationtodeterminewhichfilesarenew.

Gotowww.waproviderone.org/ediandloginusingtheprovidercredentials.

Ontheleft,clicktheOn-lineBatchClaimsSubmission(837)link.

Foreachnewdatfilecreated,clickthebrowsebutton,andalocatefile,thenclickUpload.

After15minutes,thefilesshouldregisterinProviderOne.
•GototheRetrieveHIPAABatchResponseslink,select837DfromtheTransactionTypedropdownmenu.
•ChangethefirstfiltertoUpload/SentDateandtypetoday'sdateintheboxtotheright.
•ClickGo.Youwillseleneoneforeachfileuploaded.
•Foreachfile,clicktheCustomReportResponseFilelinktoviewanyerrorsintheclaimformat.

Ifthereareerrorsatthispoint,emailderek@opendental.com.Ifnoerrorsareindicated,thenthefileformatiscorrect,but
thatdoesnotmeanthateachclaimwillbepaid.Themorningafterthefilesareuploaded,usetheClaimInquirylinktolookup
eachclaimandverifythatitwillbepaid.

ChangeHealthcareE-Claims

ChangeHealthcare(formerlyEmdeon)isane-claimsclearinghouse.

IntheMainMenu(592),clickSetup,Family/Insurance,ChangingHealthcare(formerlyEmdeon)isane-claimsclearinghouse.

IntheMainMenu(592),clickSetup,Family/Insurance,ChangingHealthcare(formerlyEmdeon)isane-claimsclearinghouse.
Website: http://www.emdeon.com/billingmanagementfordentists/

Updating to TLS 1.2
07/24/2018: Offices already using Change Healthcare to submit electronic claims must update their installation to TLS 1.2 by November 2018. TLS 1.2 is a more secure method of sending claims. The update must happen on all workstations set up to send e-claims.

To update your Change Healthcare installation, follow steps 4 through 8 under New Change Healthcare Registrations below.

New Change Healthcare Registrations
Offices wishing to use Change Healthcare can register using the steps below.

If a second office is signing up but using a different database, you must acquire a separate username and password from Open Dental. If the second office is using the same database, refer to Clearinghouse Clinic Setup.

1. Call Open Dental at 503-363-5432 and we will provide you with a Login ID and a Password.
2. Fill out a registration form and fax it to Change Healthcare at 860-289-0055.
   - Batch claim registration forms:
     - Registration $39.95 a month (PDF)
     - Registration $0.37 per claim (PDF)
   - Electronic Eligibility registration form: Registration $17.95 per provider per month (PDF)
   Note: If you are already signed up for batch claims and would like to add electronic eligibility, fill out the Electronic Eligibility form and send to Change Healthcare to complete your enrollment. If you are not signed up for claims, you can sign up for both simultaneously.
3. Download and run WebMD Eclaims Setup.exe on the workstations where you will be sending claims from. Set the Change Healthcare client program to always run as administrator. The program location is indicated in the Launch Client Program field on the Edit Clearinghouse window.


5. Right click the zip file and select Extract All....

6. Browse to and select the WebMD installation folder. Typically C:\Program Files (x86)\WebMD.

7. Click Extract in the lower right.

8. A Replace or Skip files window will appear. Select Replace the files in this destination. This will update the necessary files for claim submission.

9. In Open Dental, set up the Emdeon clearinghouse (WebMD and Emdeon are the same company) using screenshot above as a reference.

See Send Claims(489) for instructions for sending claims.

See Electronic Eligibility and Benefits(108) for electronic eligibility instructions.

If you have trouble with the claims or need payer enrollment, you may need to contact Emdeon. See https://www.changehealthcare.com/contact.

Payer Enrollment Forms:

- Batch Claims: http://www.emdeon.com/resourcelibrary/#6#269
- Real Time: http://www.emdeon.com/resourcelibrary/#6#251
- ERA: http://www.emdeon.com/resourcelibrary/#6#250
- NPI: http://www.emdeon.com/resourcelibrary/#6#265


**Electronic Eligibility**

For Denti-Cal(660) carriers, you must also enter the Denti-Cal password on the Denti-Cal Clearinghouse Setup window.

1. In the main menu, click Setup, Family/Insurance, Clearinghouses, and double click on Denti-Cal.

2. For Clearinghouse ID (ISA08) make sure DENTICAL is entered.

3. Enter the Denti-Cal password.

4. Click OK.

<table>
<thead>
<tr>
<th>Clearinghouse ID (ISA08)</th>
<th>DENTICAL</th>
<th>Also used in 1000B NM109.</th>
</tr>
</thead>
<tbody>
<tr>
<td>GS03</td>
<td>DENTICAL</td>
<td>Usually the same as ISA08.</td>
</tr>
<tr>
<td>Test or Production (ISA15)</td>
<td>P</td>
<td>&quot;P&quot; for Production, &quot;T&quot; for Test.</td>
</tr>
</tbody>
</table>

Not all values are required by each clearinghouse / carrier.

| Login ID | password |

**Insurance Categories**

In the Main Menu(592), click Setup, Family/Insurance, Insurance Categories.
Insurance categories allow automatic calculations of insurance coverage based on the procedure code.

Note: Do not alter insurance categories unless you understand what you are doing. Some changes affect benefit information for ALL insurance plans. The only known reason to change insurance categories is if you are in a country other than the United States.

**Coverage Categories**

Coverage categories have specific procedure code spans attached according to typical insurance groupings. Categories are used to calculate the actual insurance coverage for specific procedures. The categories that exist affect the categories available when creating an insurance benefit. Coverage categories are completely unrelated to procedure code categories.

- To revert to Open Dental defaults, click **Set to Defaults**.
• To reorder categories, click the up/down arrows. The General category should be at the top, because it keeps track of annual maximums for all patients.
• To add a new category, click Add, or double-click a category row to edit.

Description: The category name.

Default Percent: The category's default percentage when creating a new insurance plan (Insurance Plan(81)). Changing this number only changes the default value for future insurance plans and does not affect existing patient plans. If the percent is left blank, this category will not show as a default benefit in new insurance plans.

Is Hidden: Remove this category as a selection option on the Edit Benefit Window (Edit Benefits - Row View(91)).

Electronic Benefit Category: You must have exactly one of each E-benefit category. There can be no duplicates and no missing categories.

Coverage Spans
Each coverage category can have unlimited spans of procedure codes attached. The default spans should work for most offices. Adding extra spans does not increase complexity for the staff. They will still only see the coverage categories set up. Spans simply allow you to put whatever procedures you want into each category. A span can be as short as a single code. Spans can be deleted although this will affect patient data if the span includes a patient's procedure (it does not corrupt the data). Changes to spans will affect the treatment plans of multiple patients.

To add a coverage span, click Add Span, or double-click a coverage span row to edit.
Open Dental warns you if the code is not in the correct ADA format (at least the first 5 digits), but you can still use such codes if you wish.

If you have a category that is a subset of another span, then that category should be lower in the list.

**Insurance Filing Codes**

In the **Main Menu** (592), click Setup, Family/Insurance, Insurance Filing Codes.

Insurance filing codes are added to **Insurance Plans** (81) and are for **E-Claims** (645) only.

The most commonly used filing codes appear in the list by default.

To add a custom filing code, click Add.
Enter field information:

- **Description**: Name of the filing code.
- **Eclaim Code**: Code that is sent on electronic claim.
- **Group**: Groups are useful to query claim and carrier information. Select group from dropdown menu. Groups can be added or edited in Definitions: Insurance Filing Code Group(871)
- **Insurance Filing Code Subtypes**: Click Add to create a subtype for this Filing Code. Subtypes can be added to the Insurance Plan.

Click OK to save.

---

**Patient Fields**

In the [Main Menu](592), click Setup, Family/Insurance, Patient FieldDefs.
Custom patient fields are fields you can add to various areas of the program. Examples: second email, fax number, patient's website, trivia, signed HIPAA. They can show in several areas including:

- Patient Information area of the Family Module (59).
- Patient information area of the Account Module (150).
- Patient Information area of the Chart Module (298).
- Ortho Chart (390)
- Group Note (this option is for Orion users only)

To enter information in a custom patient field double-click the cell.
Type the information, or select from a list of options.

- Note: Information entered in a custom patient field can also be displayed in an appointment box on the schedule (see Appointment Views(7)).
- Data entered in a patient field is tied to the field name. If you edit a patient field name, any data already entered in the field will be hidden, and essentially a new field is created. To view data tied to the original field name, revert to the original name, or create a new field with the same name.

**Add or Edit Patient Fields**
To reorder patient fields, highlight the field, then click the up/down arrows.

**Display patient fields that have been renamed or hidden:**
- Checked: When a Field Def is in use by a patient, renaming or marking the field as hidden, will cause the old field and any entered data to show in grey text at the bottom of the Patient Information area.
- Unchecked: When a Field Def is in use by a patient, renaming or marking the field as hidden will cause entered data to be removed.

Click Add or double-click an existing field to edit.
**Field Name**: Enter the field label.

**Field Type**: Select the type of field.
- **Text**: Users can enter any freeform text.
- **PickList**: Users will select from a list of items. Enter one item on each line. Answers will be attached to patients as plain text.
- **Date**: Only allow users to enter dates. These dates will be attached to patients as plain text rather than as a formal date.
- **Checkbox**: Create a single checkbox that users can use to indicate yes or true.
- **Currency**: Only numeric values will be allowed. Values will be converted to currency (e.g. 1 will be converted to $1.00).

Note: Patient field defs in use cannot be deleted. Instead, check Hidden to hide them.

**Location of the Patient Field**
Custom patient fields can be available to display in all patient information areas (Chart, Account, Family, Ortho Chart), or you can set patient fields to only be available for specific patient information areas.

Note: To actually display patient fields in the Family, Account, and Chart module patient information areas, also add the PatFields to the corresponding **Display Fields** (900) category.

On the Patient Field Defs window, click Setup to open the Field Display window.
Field Location: Click the dropdown to select the location. There are four options for patient fields:
- Account: Fields available for the Display Field category AccountPatientInformation.
- Chart: Fields available for the Display Field category ChartPatientInformation.
- Family: Fields available for the Display Field category PatientInformation.
- OrthoChart: Fields that will display in the Patient Fields area of the Ortho Chart.

Note: AppointmentEdit location is for Appointment Field Defs(614) only; the Group Note location is for Orion users only.

Visible vs Hidden Fields: Determine which fields should be visible and which should be hidden. To move a field to a different grid, highlight it, then click the right/left arrow.
- Visible Fields: Fields that will show in the Ortho Chart, or when PatFields is added to the corresponding Display Field category.
- Hidden Fields: Fields that will not show.

Electronic Payer IDs
In the **Main Menu** (592), click Setup, Family/Insurance, Payer IDs.

Electronic Payer IDs are sometimes used when submitting **E-Claims** (645).

Make sure to always verify that the electronic payer ID for a carrier is correct. If you use the wrong ID you may have to resubmit claims at your own expense. Some payers may have commercial and government payer IDs, and we may not list both. If in doubt and sending a large number of claims to a payer you have not previously sent to using Open Dental, you should verify the ID with the carrier.

This list can be used as a reference when you need to find an electronic payer ID. This list also appears when you click Search IDs on the **Insurance Plan** (81) Edit Window. Another place to enter the ID is in **Carriers** (1237). However, electronic IDs attached to a carrier do not automatically appear in this list.

A list of known electronic payer IDs are already setup in Open Dental.

To add a new electronic payer ID, click Add.
Enter the payer ID, carrier name, and any comments. If this is Medicaid, check the Is Medicaid box.

Click OK to save.

**Account Module Preferences**

In the [Main Menu](592), click Setup, Account.
Alternatively, click Setup, Module Preferences (927), Account tab.

**Pay/Adj**

**Automatically store credit card tokens**: If using XCharge (OpenEdge) (173) or PayConnect Window (168), this option is usually checked. It determines the default setting for the Save Token check box when charging a credit card using XCharge or PayConnect. A token is encrypted credit card information (card number and expiration date). Tokens must be stored to use CC Recurring Charges (1430).

- **Checked**: Set the default setting for the Save Token box to checked.
- **Unchecked**: Sets the default setting for the Save Token box to unchecked. Useful when you require the credit card to be presented for all transactions.

**Patient Payments Use**: Determines the default clinic for patient payments (Payment (153) window). There are three options:

- **SelectedClinic**: Use the clinic selected in the main menu under Clinics.
- **PatientDefaultClinic**: Use the patient's default clinic as set on the Edit Patient Information (62). If the patient's clinic is Unassigned, the default clinic will be none.
- **SelectedExceptHQ**: Use the clinic selected in the main menu, unless it is Headquarters. In that case, use the patient's clinic.

**Payments prompt for Payment Type**: Determines whether or not a payment type is automatically selected when entering a patient payment.

- **Checked**: Users must manually select the payment type when entering a payment (no default selected).
- **Unchecked (default)**: The first payment type in the list will be selected by default.

**Default unearned type for unallocated paysplits**: Set the default Unearned Type for paysplits that are not allocated to providers. Customize options in Definitions: PaySplit Unearned Types (880). Defaults to Prepayment.

**Finance charge adj type**: Select the adjustment type created for Finance Charges (1428).
Billing charge adj type: Select the adjustment type created for Billing Charges (1428).

Sales Tax adj type: Select the default adjustment type for Sales Tax (207) (e.g. Sales Tax). Only addition adjustment types show as options.
Note: Customize adjustment type options in Definitions: Adj Types (841).

Payment Plan adj type: Set the negative adjustment type used when adding payment plan adjustments.

Sales Tax percentage: Set the sales tax percentage to apply.

Bad Debt Adjustment Types: Mark specific adjustment types as Bad Debt (debts that won't be recovered). This data can be used in custom queries.
1. Click Edit to view a list of available adjustment types.
2. Highlight the adjustment types to mark as bad debt. Press Ctrl while clicking to select multiple options.
3. Click OK. The bad debt adjustment types will list.

Currently selected bad debt adjustment types are highlighted in blue. Check Show hidden to reveal adjustment types marked hidden.

Allow future dated payments (not recommended): Determines whether or not users can enter future dated patient payments.
- Checked: Allow users to enter future dated payments.
- Unchecked: Block users from entering future dated payments.

Note: While we allow you to do so, we do not recommend allowing future dated payments and other debits (credits) because it can cause accounting problems and violate generally accepted accounting principles (GAAP). Only enable this preference at your own risk.
- When you DO NOT include future dated debits in balance calculation, a patient may appear to owe the debit amount and you may attempt to collect it (again).
- When you DO include future dated debits in balance calculation, the balance on reports run on historical dates will not match the actual balance on the historical date since the future dated payment will be excluded.
• If either this preference, or the preference for *Allow future dated transactions* (Misc section) are enabled, future dated patient payments are allowed.

• If both this preference, and the preference for *Allow future dated transactions* (Misc section) are disabled, future dated patient payments are not allowed.

**Allow emailing credit card receipts:** Determines whether or not the Email Receipt button is enabled in the Payment window.

**Enforce Valid Paysplits:** Determines whether or not users are forced to allocate patient payments to procedures and unearned income. See *Payment Preferences*(159) for more details.

• Enforce Fully: Open Dental will automatically suggest payment splits (paysplits) allocated to procedures, procedure treating provider, default clinic, and default unearned income types. Users can modify suggested paysplits, but are required to allocate to procedures or unearned income types. Credits on Payment Plans are also required to be attached to procedures.

• Auto-Split Only (default): Open Dental will automatically suggest paysplits allocated to procedures, procedure treating provider, default clinic, and default unearned income types, but user can modify splits or choose to remove allocations to procedures or unearned income types.

• Don't Enforce (old behavior): Open Dental will only suggest paysplits allocated to the procedure's treating provider. Users are not required to allocate to procedures or unearned income types.

**Allow prepayments to providers:** Determines whether to allow or prevent a user from assigning a provider to a prepayment.

• Check: Allows users to assign a provider to a prepayment. Useful to pay providers on unearned income.

• Uncheck: Prevents users from assigning a provider to a prepayment. If a provider is assigned, the unearned income type will change to None.

Note: One reason for this preference is that some provider contracts may require the owner to pay providers on unearned income. For example, this makes sense for orthodontists who would otherwise remain unpaid when treatment is lengthy. Allowing unearned income to have a provider, even when Enforce Fully is turned on, is how to accomplish this. When the unearned income is allocated to a procedure later, a negative paysplit will be made along with a positive paysplit to move the money to the procedure (allocate it). If the same provider was paid previously that has now completed the procedure(s), the net income for that provider due to the allocation is zero. If the provider is different, there will be negative income for one provider and positive for the other.

**Enforce Valid Adjustments:** Determines whether clinic and provider of adjustments match clinic and provider of attached procedures. Also determines whether attaching adjustments to procedures is required or optional. Setting will only apply when adding new adjustments or editing existing adjustments.

• Enforce Fully: Attaching procedures to adjustments is required. Clinic and provider assigned will be the same as procedure. Users with the *Setup* security permission may edit the adjustment to assign a different clinic and provider than the attached procedure.

• Link Only: Clinic and provider assigned will be the same as procedure. Users may edit the adjustment to assign a different clinic and provider than the attached procedure.

• Don't Enforce: The patient’s default clinic and provider will be assigned to the adjustment. Users may edit the adjustment to assign the same clinic and provider as the procedure.

Note: Attaching adjustments through the *Procedure*(303) Edit Window will always assign the procedure clinic and provider to the adjustment.

**Auto-split payments:** Determines the logic for automatic paysplit allocation suggestions when entering patient payments.

• Adjustments (default): Open Dental will automatically suggest paysplits allocated to the oldest positive adjustment, then follow FIFO (First In First Out) accounting logic for the remaining outstanding charges.

• FIFO: Open Dental will automatically suggest paysplits allocated to the oldest, completed procedures with outstanding charges.

**Hide paysplits from Payment window by default:**
- Checked: Current Payment Splits and Outstanding Charges will be hidden by default when the Payment window is opened.
- Unchecked: Current Payment Splits and Outstanding Charges will show by default when the Payment window is opened.

**Treatment Planned PrePayments:**

**Allow prepayments to allocate to treatment planned procedures:** Determines whether prepayments are allowed to be allocated to treatment planned procedures.
- Checked: Allow attaching treatment planned procedures to payments. Treatment planned procedures will appear as (TP) in the Payment window.
- Unchecked: Do not allow attaching treatment planned procedures to payments. TP procedures will be hidden from the Payment window.

**TP prepayments are non-refundable:** Only visible when Allow prepayments to allocate to treatment planned procedures is checked. Determines how the prepayment is handled when the associated appointment is broken.
- Checked: If an appointment is broken using the procedure code D9986 (missed), the prepayment money will automatically transfer to the broken appointment procedure code. If the appointment is broken using procedure code D9987 (cancelled), the prepayment money will remain on the original procedure.
- Unchecked: Prepayment money will not transfer to a broken appointment procedure code.

**Default treatment planned procedure unearned type:** Determines which Unearned Type (880) is associated with prepayments allocated to treatment planned procedures. Select the default type from the dropdown menu. Customize options in Definitions: PaySplit Unearned Types (880). Defaults to Treat Plan Pre-Prepayment.

**Insurance**

- Show provider income transfer window after entering insurance payment
- Set medical claims to institutional when using medical insurance
- Claim Form treating provider shows “Signature On File” rather than name
- PPO write-off description (blank for “Write-off”)
- Claim attachment export path: C:\TempImages\n
**Payment exceeds procedure balance:**
- Allow

**Creating claims with $0 procedures:**
- Allow

- Exclude ‘None’ as an option on Custom Tracking Status
- Disallow write-offs greater than the adjusted procedure fee
- Prompt for secondary claims
- Recalculate estimates for received claim procedures

Show provider income transfer window after entering insurance payment:
• Checked: Automatically open the Payment window after entering Claim Payments(231) so you can fine tune provider balances by transferring income.
• Unchecked: The Payments window will not automatically open.

Set medical claims to institutional when using medical insurance:
• Checked: The default ClaimType(228) will be set to institutional when a medical claim is created.
• Unchecked: The default claim type will be set to medical when a medical claim is created.

Claim Form treating provider shows 'Signature On File' rather than name:
• Checked: If the provider also has Signature on File checked on the Provider(1255), Signature on File will print in the TreatingDentistSignature field on the ADA 2012 and 2018 Claim Forms(644).
• Unchecked: If the provider also has Signature on File checked on the Edit Provider window, the provider's name will print in the TreatingDentistSignature field on the ADA claim form.

PPO write-off description (blank for “Write-off”): Determines the wording for insurance write-offs used in the Description column of Account module and on statements. The default will be Write-off if left blank.

Claim Attachment Export Path: Enter the path to the folder where images attached to a claim will be exported. See Claim(208).

On medical e-claims, send treating provider as ordering provider by default: Set the default ordering provider sent in medical e-claims. Also see E-Claims Complexities(496).
• Checked: The procedure's treating provider will be the default ordering provider.
• Unchecked: There will be no default ordering provider.

On e-claims, send treating provider info for each separate procedure: Only applies to e-claims. Paper claims have no place to include information for more than one treating provider. This option should be checked unless you have a very good reason for needing to not send information about treating providers.

Require ACN# in remarks on claims with ADDP group name: Claims created with group name ADDP will prompt for an ACN number. This was added for one specific customer, and can be ignored by most practices.

Allow procedure adjustments from Edit Claim window:
• Checked: Right click procedures on the Edit Claim window to add a procedure adjustment.
• Unchecked: The right click Add Adjustment option will not be available.

Payment exceeds procedure balance: Determines whether or not users are allowed, warned, or blocked from allocating an insurance payment that is greater than the procedure's remaining balance (procedure fee - payments - writeoffs + adjustments).
• Allow: Users can allocate an insurance payment that is greater than the procedure's remaining balance and will not be warned.
• Warn: Users can allocate an insurance payment that is greater than the procedure's remaining balance but will receive a warning.
• Block: Users will not be allowed to finalize insurance payments for insurance amounts that are greater than the procedure's remaining balance. They will receive a prompt detailing the balance but will not be allowed to proceed with the payment.

Allow future payments: Determines whether or not users are allowed to enter insurance payments with a future Payment Date.
• Checked: Create an insurance payment with a future payment date. Reports will not reflect this payment until the payment date.
• Uncheck: Prevent users from entering a payment with a future payment date. Users will be prompted with a warning message and they will not be able to finalize the payment until the date is changed.

• Note: If either this preference or the preference for Allow future dated transactions are enabled, future dated insurance payments are allowed.
If either this preference or the preference for *Allow future dated transactions* are disabled, future dated insurance payments are not allowed.

**Claim Identification Prefix:** Change the default format of the claim ID. This number is assigned to a claim using the prefix selected, then adding an auto-generated claim number. Useful for internal tracking of claims. Click **Replacements** to select a prefix.

**Creating claims with $0 procedures:** Determines whether users are allowed, warned, or blocked from creating claims with $0 procedures.

- **Allow:** Users can create claims with $0 procedures.
- **Warn:** Users are prompted with a warning message when attempting to create a claim with $0 procedures. Click OK to create the claim or cancel to exit without creating a claim.
- **Block:** Users cannot create a claim with $0 procedures.

**Exclude 'None' as an option on Custom Tracking Status:** Determines whether *None* is an available status option in the **Edit Claim - Status History Tab**.

- **Checked:** Removes *None* from the status options. The tracking status will default to the first custom option in the list.
- **Unchecked:** *None* is the default status option.

**Disallow write-offs greater than the adjusted procedure fee:** Determines whether or not write-offs can be greater than the procedure fee (fee - adjustments).

- **Checked (default):** Prevent write-offs from exceeding the adjusted procedure fee.
- **Unchecked:** Allow write-offs that exceed charged fee after considering adjustments. May result in unintended credit on patient account.

**Prompt for secondary claims:** Determines how secondary insurance claims are handled.

- **Checked:** When primary claim is received, a popup will appear to determine how to handle outstanding secondary claim. Options will be to change claim status to *Waiting to Send*, send the secondary claim now, or the do nothing.
- **Unchecked:** When primary claim is received, a popup will remind the user a secondary claim is outstanding, but no options are presented.

**Recalculate estimates for received claim procedures:** Determines if estimates can be changed for a procedure that has been received.

- **Checked:** Allows users to recalculate estimates on received claim procedures.
- **Unchecked:** Does not allow users to recalculate estimates on received claim procedures.

**Canadian PPO insurance plans create lab estimates:** Determines if lab fee estimates should be created for PPO insurance plans.

- **Checked:** Lab fee estimates will be created for PPO insurance plans, visible on claims.
- **Unchecked:** Lab fee estimates will not be created. Users will need to manually enter lab fees when receiving claims.

**Note:** This feature is only available for Canadian databases. See [Canada Lab Fees](#) for more details.

**Misc**
Balances don't subtract insurance estimate: Be careful. This will cause estimated balances due to exclude estimated insurance payments. This is generally only used if your patients are responsible for all treatment as it is done, and you don't accept assignment of insurance benefits. All insurance payments then go directly to the patients without involving the dental office.
- Unchecked (default): Balance due in the Account module and statements will include estimated insurance payments. The captions in the Account module will be Total, InsEst, Est Bal (bold red), and Pat Est Bal.
- Checked: Balance due in the Account module and statements will exclude estimated insurance payments. The captions in the Account module will be Balance (bold red), Ins Pending, After Ins, Pat Est Bal.

Aging calculated monthly instead of daily:
- Unchecked (default): Aging is automatically calculated daily. This is the recommended setting.
- Checked: Aging must be manually updated using the Aging(1423) tool. The patient's account will be based on the last calculated date. The last calculated date will also be the default in the Aging of A/R report. We also recommend setting Global Security Lock Dates(1122).

Show Payment Numbers in Account Module: This is needed for countries outside the U.S. and in Canada.
- Checked: Payment numbers will show in the payment description.
- Unchecked: Payment numbers will not show in the payment description.
Use UCR fee for billed fee even if PPO fee is higher: Set which fee is used as the billed fee when a PPO fee is higher than the UCR fees (PPO Insurance Plan(114) only). Typically, if the PPO fee is higher than a provider's UCR fee, the PPO fee is used as the billed fee.
- Unchecked: For all PPO plan types, the PPO fee will be used as the billed fee if it is higher than the provider's UCR fee.
- Checked: For all PPO plan types, the UCR fee will be used as the billed fee, even if the PPO fee is higher.

Invoices’ payments grid shows write-offs: Determines whether or not insurance write-offs are included in the Payments grid on invoices.
- Checked: Include insurance write-offs for procedures in the Payments grid.
- Unchecked: Do not include insurance write-offs.

Prompt user to allocate unearned income after creating a claim: Determines whether or not the user will be prompted to allocate unearned income to completed procedures when creating a claim.
- Checked: When a claim is created, the payment window will prompt the user to allocate unearned income to completed procedures (if there is unearned income not yet allocated).
- Uncheck: Prevents the payment window from prompting the user to allocate unearned income.

Allow future dated transactions:
- Checked: Allows future dating of transactions (e.g. insurance payments, adjustments, etc).
- Unchecked: Prevents future dating of transactions.

- Note: If this preference is enabled, Allow future payments and Allow future dated payments are allowed.
- If this preference is disabled, Allow future payments and Allow future dated payments are not allowed.

Transactions attached to procedure offset each other before aging: Determines whether credits attached to a procedure apply to the procedure’s charges before aging.
- Filled: When filled Open Dental will use the recommended setting. This preference is recommended to be checked. Click to change the preference to checked or unchecked.
- Checked: Adjustments and payment plan credits attached to a procedure are summed by date. If the sum of the attached charges and credits results in a credit, the credit is applied to the balance of the procedure's aging category. Any remaining credit is aged normally.
- Unchecked: Standard aging is applied. See Aging(1423).

Payment Plans exclude past activity by default: Determines the default state for the Exclude Past Activity check box on the Payment Plan(239).
- Checked: The box is checked by default.
- Unchecked: The box is unchecked by default.

Pay Plans use Sheets: Determines whether printed payment plans will use the classic layout or a custom layout designed in sheets.
- Unchecked (default): Printed payment plans will use the classic format (not sheets).
- Checked: Printed payment plans will use the custom payment plan layout designed using sheets. A payment plan sheet can allow an electronic signatures. See Payment Plan Layout(1174).

Pay Plan charge logic: Determines how charges and credits for Patient Payment Plans(239) show in the patient account ledger and whether they affect balances, aging, and reports. This logic does not apply to insurance payment plans and will continue to use the old logic
- Do Not Age (Legacy): Payment plan debits (amounts due) and payments only show within the payment plan and will not affect balance or aging.
  - Payment plan debits are totaled in the Payment Plans grid under Due Now.
  - Payment plan payments do not show in the ledger but in the payment plan. Double-clicking the plan row is the only way to view payment plan payments.
  - One payment plan credit (PayPln) will show as a single line item in the patient account ledger, thus reducing the total account balance by the amount. The credit amount is based on the Tx Completed Amt set in the payment plan.
Other payment plan credits, debits, and payments do not show in the ledger nor do they affect balances or aging.

- The total A/R in the Aging of A/R report will not include payment plan due amounts.
- Only changes to the Tx Completed Amount affect aging and production and income reports.
- Payment plan amounts are not included on the Receivables Breakdown Report.

**Age Credits and Debits (Default):** Payment plan debits, credits, and payments will show as line items in patient account ledger and affect balances and aging.

When the patient is in the same family as the payment plan guarantor, the behavior is as follows.

- Payment plan amounts due (PayPln: Debit) and credits (PayPln: Credit) show as line items in the patient account ledger.
- Payment plan payments show in the account ledger.
- Payment plan due amounts are included in the patient's balance.
- Payment plan amounts due and payments are considered when calculating aging.
- Payment plan credits and debits are included on the Receivables Breakdown report.
- Changes made to historical payment plan charges will affect historical information (e.g., Aging of A/R, Production and Income reports). When the patient is in a different family than the payment plan guarantor, the behavior is as follows.

- Payment plan amounts due (PayPln: Debit) show as line items in the guarantor's account ledger.
- Payment plan credits (PayPln: Credit) show as line items in the patient's account ledger.
- Payment plan payments show in the guarantor's account ledger.
- Payment plan due amounts are included in the guarantor's balance.

**Age Credits Only:** Patients are credited for payment plans when the credit comes due, but debits all exist separately from the account ledger.

- Each payment plan credit line item will show in the account ledger, sorted by Tx Credit date.
- Payment plan amounts due only show in the Payment Plan grid. They do not show in the account ledger.
- Payment plan amounts due will not be considered when calculating balances and aging.
- Payment plan credits and debits will not be included on the Receivables Breakdown report.
- Changes made to historical payment plan credits will affect historical information (e.g., Aging of A/R, Production and Income reports).

**No Charges to Account (Rarely Used):** Patients are not credited for payment plans so the account balance is aged normally.

- Payment plan amounts due only show in the Payment Plan grid. They do not show in the account ledger.
- Payments to payment plans show in ledger and payment plan.
- Payment plan amounts will not be included on the Receivables Breakdown report.

**Dynamic Pay Plan run time:** Choose a time of day when the Open Dental Service will calculate charges for Dynamic Payment Plans.

**Commlogs auto save:** Determines whether or not Commlog entries save every ten seconds automatically after a change is made.

- Checked: Commlogs are auto-saved.
- Unchecked (default): Commlogs are not auto-saved.

**Show family comm entries by default:** Determines whether family commlogs show by default. You must restart Open Dental on all workstations for this preference to take effect.

- Checked: The Show Family Comm Entries box in the Account Module, Show tab is checked by default.
- Unchecked: This box is not checked by default.

**Recurring charges use primary provider:** Determines to which provider Recurring Charge payments will be applied.

- Checked: Payments will be applied to the patient's primary provider.
- Unchecked: Payments will be applied to the provider that the family owes the most money to.

**Recurring Charges use transaction date:** Select how the payment date is determined when running recurring charges.

- Checked: Payments will use the transaction date (the date the recurring charge is run).
- Unchecked: Payments will use the date the charge is scheduled to be processed (see Authorize Recurring Charges).
Recurring charges run automatically: Option to automate the recurring charge tool to run at a specific time during the day.
- Checked: Recurring charge tool will run automatically at a set time. Set the Recurring charges run time below.
- Unchecked: Disable the automatic run time to run the recurring charge tool manually.

Recurring charges run time: Set the time of day to automatically run the recurring charge tool. Use a 12-hour or 24-hour time format (include AM or PM).
Note: X-Web must be enabled for X-Charge users to use Recurring Charges.

Payment type for CC: Select a payment type to assign to credit card payments processed through the CC Recurring Charges tool. Selecting (default) will use the payment type assigned in the XCharge Setup, PayConnect Setup, and PaySimple Setup, payment settings. ACH recurring charges will use the type assigned in the Payment Type ACH dropdown of the PaySimple Setup window.

Allow recurring charges to run in the absence of a patient balance: Determines whether or not the Run charge even if no patient balance present check box is an available option in the Credit Card Edit window.
- Check: The check box will be available by default.
- Uncheck: The check box will not be available.

Repeating charges runs aging after posting charges: Determines whether or not Aging is run after repeating charges are posted through the automated repeating charge service or repeating charges tool.
- Check: Aging is run automatically on accounts with newly posted repeating charges (checked by default).
- Uncheck: Prevent aging from running automatically after repeating charges have posted. To run aging using other methods, see Aging.

Repeating charges run automatically: Option to automate repeating charges to run at a specific time each day.
- Check: Repeating charges are posted automatically at a set time every day. Set the Repeating charges run time below.
- Uncheck: Disable the automatic run time to manually run the Repeating Charges tool.

Repeating charges run time: Set the time of day to automatically post repeating charges. Use a 12-hour or 24-hour time format and include AM or PM. The OpenDentalService must be installed and running during the scheduled run time.

Treatment Plan Module Preferences
In the MainMenu, click Setup, Treat'Plan.
Alternatively, click Setup, Module Preferences (927), Treat'Plan tab.

Here you can set default options and settings for the Treatment Plan Module (283). Treatment Plan preferences are divided into three sections.

- General Treat'Plan
- Frequency Checking
- Ins History

**General Treat'Plan**

**Default Note:** The default note that shows on a treatment plan (in the Note box in the Treatment Plan module). It can be very long and complex if needed and supports Quick Paste Notes (1088). If the default note is changed, you will be asked if you want to change the default note for existing unsaved treatment plans.

- If you choose Yes, the note will only change on unsaved treatment plans that use the default note. Notes that have been customized in unsaved treatment plans and notes in saved treatment plans will not be replaced.
- If you choose No, only notes in new treatment plans will show the new default note.

**Show completed work on graphical tooth chart:** Set the default option for showing completed procedures on the printed tooth chart. The option can also be changed in the Treatment Plan module by checking/unchecking the Graphic Completed Tx under Show.

- Checked: By default completed procedures will show on the printed tooth chart.
- Unchecked: By default completed procedures will not show on the printed tooth chart.

**Procedure discount adj type:** The default adjustment type that is added to the patient account when treatment planned procedures with TP Procedure Discount (292) are set complete. The available options are set in Definitions, Definitions: Adj Types (841).

**Procedure discount percentage:** The default percentage used for procedure discounts.

**Itemize Treatment Plan:** Set whether printed treatment plans will show itemized fees or grand total only.

- Checked (default): Printed treatment plan show itemized procedures.
- Unchecked: Printed treatment plans only show the Total amount and no itemized fees.
Save signed Treatment Plans to PDF: Determines if signed treatment plans are saved to the Images Module.

- Checked: All signed treatments plans will be automatically be saved as PDFs.
- Unchecked: Signed treatment plans will not be automatically saved as PDFs.

Sort Procedures By: Determines how procedures in the Treatment Plan module are sorted by default. Also see Procedure Sort Order(478).

- Tooth: Procedures will be sorted by tooth number.
- Order Entered: Procedures will be sorted in the order they are entered.

Frequency Checking

Enable Insurance Frequency Checking: Determines whether a procedure's frequency limitations affect insurance estimates (e.g. BWs, Panos/FMX, Exams, or custom frequency limitation benefits). See Frequency Limitations(104).

- Checked (default): Check for insurance frequency limitations when calculating insurance estimates in the Treatment Plan module. Also check for frequency conflicts when scheduling an appointment.
- Unchecked: Frequency limitations will not affect insurance estimates and are for reference only.

The following settings determine which codes are affected by each frequency limitation, if insurance frequency checking is enabled. Separate multiple codes by comma (e.g. D0272,D0274).

- Bitewing Codes: The procedure codes affected by the BWs frequency limitation.
- Pano/FMX Codes: The procedure codes affected by the Pano/FMX frequency limitation.
- Exam Codes: The procedure codes affected by the Exams frequency limitation.
- Cancer Screening Codes: The procedure codes affected by the Cancer Screenings frequency limitation.
- Prophylaxis Codes: The procedure codes affected by the Prophylaxis frequency limitation.
- Fluoride Codes: The procedure codes affected by the Fluoride Through Age limitation and Fluoride frequency limitation.
- Sealant Codes: The procedure codes affected by the Sealants Through Age limitation and Sealants frequency limitation.
- Crown Codes: The procedure codes affected by the Crown frequency limitation.
- SRP Codes: The procedure codes affected by the SRP frequency limitation.
- Full Debridement Codes: The procedure codes affected by the Full Debridement frequency limitation.
- Perio Maintenance Codes: The procedure codes affected by the Perio Maintenance frequency limitation.
- Dentures Codes: The procedure codes affected by the Dentures frequency limitation.
- Implant Codes: The procedure codes affected by the Implant frequency limitation.

Ins History

The following settings determine which code groups are affected by Insurance History(136). Only the first code from the group defined in the Frequency Checking section (above) should be entered.

- Bitewing Code: The procedure code group that affects Bitewing limitations.
- FMX/Pano Code: The procedure code group that affects Pano/FMX limitations.
- Exam Code: The procedure code group that affects Exam limitations.
- Prophylaxis Code: The procedure code group that affects Prophylaxis limitations.
- Full Debridement Code: The procedure code group that affects Full Debridement limitations.
- Perio Maintenance Code: The procedure code group that affects Perio Maintenance limitations.
- Perio Scaling LL Code: The procedure code group that affects limitations for Perio Scaling in the Lower Left.
- Perio Scaling LR Code: The procedure code group that affects limitations for Perio Scaling in the Lower Right.
- Perio Scaling UL Code: The procedure code group that affects limitations for Perio Scaling in the Upper Left.
- Perio Scaling UR Code: The procedure code group that affects limitations for Perio Scaling in the Upper Right.
Chart Module Preferences

In the **Main Menu** (592), click Setup, Chart, Chart Preferences.

Alternatively, click Setup, **Module Preferences** (927), Chart tab.

The following preferences determine functionality handled in the **Chart Module** (298).

**Note:** To choose a default **Chart Layout** (460) see **Sheet Def Defaults** (1151).

**Allow setting procedures complete:** Determines whether or not users can set individual procedures complete. We recommend only allowing appointments to be set complete, not individual procedures.
- Checked: Users can set individual procedures in an appointment complete.
- Unchecked: Users can only set appointments as complete, not individual procedures.

**Indicator that patient has no problems:** For EHR users. Select the problem that will be used to indicate the patient has no problems. Usually linked to a problem called None. **Problem List** (1250)

**Indicator that patient has no medications:** For EHR users. Select the medication that will be used to indicate the patient has no medications. Usually linked to a medication called None. **Medications List** (1246)

**Indicator that patient has no allergies:** For EHR users. Select the allergy that will be used to indicate the patient has no allergies. Usually linked to an allergy called None. **Allergy List** (1221)

**Use medical fee for new procedures:** Determines which fee is used for new procedures when cross-coding medical codes to procedure codes. See **Cross Code** (734).
- Checked: The fee of the medical code associated with the procedure code will be used.
Use ICD-10 Diagnosis Codes (uncheck for ICD-9): Determines which ICD-10 Codes are used for procedures.
- Checked: Assign ICD-10 diagnosis codes to procedures.
- Unchecked: Assign ICD-9 diagnosis codes to procedures.

Default ICD-10 code for new procedures: Click [...] to select a default Diagnosis Code that will be attached to new procedures. This code will be the first code listed on the Procedure - Medical Tab. It is often used for medical insurance, especially eClinicalWorks. The code system (ICD-9 or ICD-10) is determined by the Use ICD-10 Diagnosis Codes preference above.

Procedure locking is allowed: Not used by most offices. See Procedure Lock.
- Checked: Allows users to permanently lock completed procedures.
- Unchecked: Procedure locking is not allowed.

Non-Patient warning: Determines if a warning message shows when a non-patient record is opened in the Chart module.
- Checked: When a patient with a NonPatient status is selected from the Chart module, a warning message will show. Set status on the Edit Patient Information window.
- Unchecked: A warning will not show.

Medication order default days until stop date (0 for no automatic stop date): Enter the default number of days from a medication order's start date to set the stop date.

Screenings use Sheets: Select whether Public Health Screening uses the classic format or a custom form designed in Sheets.
- Unchecked (default): Screenings will use the classic format (not Sheets).
- Checked: Screenings will use the custom screening form designed using Sheets. See Screening Layout.

Procedures Prompt for Auto Note: Determines whether prompts in an unanswered Auto Notes are triggered when a user reopens a completed procedure. The default note must contain an auto note (Procedure Code).
- Checked: When a user reopens a completed procedure, and an unanswered auto note is part of the default note, auto note prompts will show and allow a response.
- Unchecked: No auto note prompts will show when a user reopens a completed procedure.

Require use of suggested auto codes: Determines what options a user has when Auto Codes are triggered while entering treatment.
- Checked: User must accept the recommended procedure code change (Yes) or return to the Procedure Info window to change information manually (Edit Proc).
- Unchecked: User has the option to accept the recommended procedure code change (Yes) or proceed with a mismatch (No).

Allow estimates to be created for backdated completed procedures: Not recommended. Determines whether or not insurance estimates are created when a procedure is entered with a previous date (earlier than today) and an entry status of Complete. Typically only used by those regularly enter completed procedures for previous dates.
- Checked: Insurance estimates will be created when a procedure is entered with a previous date (earlier than today) and an entry status of Complete.
- Unchecked: Insurance estimates are not created when a procedures is entered with a previous date and an entry status of Complete.

Allow digital signatures: Determines whether or not procedure notes can be signed using an electronic signature stamp.
- Checked: Procedure notes can be signed using an electronic signature stamp. An E will show in the signature box on the Procedure.
Procedure fee update behavior: Determines the prompt and behavior when changing the provider on a procedure. Determines if changing the provider will also change the procedure fees when they are different, and if a prompt will appear.

- No prompt, don't change fees: (default) Procedure fees will not change and no prompt will appear.
- No prompt, always change fee: Procedure fees will change without a prompt.
- Prompt - When patient portion changes: Procedure fees will change and a prompt will appear when the fee change affects the patient portion. Click Yes to update the fee.
- Prompt - Always: A prompt will appear whenever procedure fees change. Click Yes to update the fee.

Do not allow different procedure and claim procedure providers when attached to a claim: Determines whether or not changing the provider on a procedure will also change the provider on attached Claim Procedures (claimprocs) that are attached to a claim. Most users will leave this checked to prevent provider mismatches. See Claimproc Provider(224) for additional workflow instructions.

- Checked: When you change the provider on the Edit Procedure window, providers on attached claim procedures will change to match, as long as the claim procedure Status is not received or supplemental.
- Unchecked: When you change the provider on the Edit Procedure window, providers on attached claim procedures will not change.

Note: Claim procedures not attached to a claim (e.g. for insurance estimates) always inherit the procedure provider.

Rx use selected clinic from Clinics menu instead of the selected patient's default clinic: When checked, will use the current user's selected clinic rather than the clinic assigned to the patient.

OpenDentalService alerts for schedule non-CPOE radiology procedures: See EHR Radiology Order List(458).

- Checked: Alerts user when there are non-CPOE radiology procedures treatment planned.
- Unchecked: Does not alert user when there are non-CPOE radiology procedure treatment planned.

Prompt for Planned Appointment: Determines whether or not a user is prompted to create a planned appointment when a patient has procedures that were treatment planned today.

- Checked: Prompts user to create a planned appointment using the highest priority procedures when they have non-diagnostic/preventive procedures that were treatment planned today. To work, patient also cannot have any future scheduled appointments for procedures that would normally be charted and treatment-planned (e.g. fillings, crowns, other non-diagnostic/preventive procedures). Prompt occurs when changing modules.
- Unchecked: Does not prompt to create a planned appointment.

Reset entry status to 'TreatPlan' when switching patients: Set the default setting for Entry Status on the Enter Treatment(301) when you switch patients. Usually, treatment is entered with TreatPlan status. If you change the status to enter existing treatment, it’s easy to forget to set the status back to TP.

- Checked: Automatically sets the default Entry Status to TreatPlan every time you switch patients.
- Unchecked: The setting will not automatically change. The automatic behavior can be annoying for offices that prefer to enter completed procedures directly from the Chart module without also entering appointments.

Tooth Nomenclature: Select the tooth numbering system to display on the Graphical Tooth Chart(464) and in reports. Open Dental supports 4 different tooth numbering systems:

- Universal (Common in the US, 1-32): Valid tooth numbers are 1-32 and A-T. For supernumerary teeth, valid values are 51-82 and AS-TS. Permanent supernumerary tooth numbers add 50 to the tooth number (tooth 1 = 51). Primary supernumerary tooth numbers add an S (tooth A = AS). Procedures for supernumerary teeth do not show on the Graphical Tooth Chart, but they do get billed to insurance. Also see Supernumerary Teeth(312).
- FDI Notation (International, 11-48), 51-85 for primary teeth: For Canadian users, supernumerary teeth can be entered as 99.
- Haderup (Danish)
- Palmer (Ortho)
Note: These numbering systems do not change how any data is stored in the database. You can freely switch back and forth between the different systems.

**Procedure Group Notes aggregate**: Determines what happens when Procedure Group Note(479) are created for two or more procedures.
- **Checked**: When a group note is created for two or more procedures that also have procedure notes, all notes will be combined into one group note.
- **Unchecked**: Notes will not be combined.

**Use provider color in chart**: Determines what setting the background color for completed procedures in the Chart module, Progress Notes is based on.
- **Checked**: Background color of completed procedures will be based on the provider's Appointment Color (set on the Provider(1255)).
- **Unchecked**: Background color of completed procedures will be white, unless the procedure is today, in which case the background color is determined by the setting in Definitions: Misc Colors(876), Chart Today's Procs.

**Perio exams always skip missing teeth**: Determines the behavior for teeth marked missing when using the Perio Chart(382).
- **Checked**: When a new perio chart exam is created, any new missing teeth are automatically marked as skipped teeth.
- **Unchecked**: Only the first perio chart exam will automatically mark missing teeth as skipped. Subsequent exams will not.

**Perio exams treat implants as not missing**: Determines if teeth with implant procedure codes (paint type of implant) are considered as missing in the perio chart. Missing status may affect whether the tooth is skipped or not (see preference above).
- **Checked**: Teeth with implants are not considered missing.
- **Unchecked**: Teeth with implants are considered missing.

**Procedure Code List sort**: Choose a default sort option for the Procedure Codes(1195) List.

**Procedure notes merge together when concurrency issues occur**: If the same procedure note is edited by two or more users at the same time, each note added will merge together. Each note will show separately and will include the date, time, and user.

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**EHR Setup Window**

In the MainMenu(592), click Setup, Chart(298), EHR.
Before entering patient data for EHR, you must define information so that it is available for selection. Several setup areas are accessed from the EHR setup window.

Settings: Define global meaningful use stage settings, severity levels for drug interaction alerts, and default encounter and pregnancy codes used in CQMs.

Allergies: Access the Allergy List (1221).

Vaccine Def: Define any vaccines you administer. Usually dental offices do not give vaccines. See EHR Vaccine Setup (718).

Drug Manufacturers: Set up EHR Vaccine Drug Manufacturers (719) for the vaccines you administer.

Drug Units: Set up EHR Vaccine Drug Units (720) for the vaccines you administer.

Reminder Rules: (optional) Set up rules for patient reminders. Rules are not required to document that a reminder has been sent.

Inbound Email: Define Email Setup (747).

Educational Resources: Define Educational Resources that will be triggered for patients based on specific conditions.

Patient Portal: Set up the Patient Portal Feature.

Provider Keys: Enter EHR Annual Provider Keys (723).

Code Systems: Download and view coding systems that are attached to patient data.

- ICD 9: View or search ICD-9 or ICD-10 codes that have been imported.
- RxNorms: View or search that have been imported.
- SNOMED CTs: View or search SNOMED CT codes that have been imported.
- LOINCs: View or search LOINC codes that have been imported.
**CDS Triggers**: Configure Clinical Decision Support (CDS) interventions and permissions by user. See [EHR Configure CDS Rules](729) and [EHR CDS Permissions](731).

**Time Synchronization**: View the [EHR NIST Time Synchronization](731) window.

**Internal OID Registry**: Set up [EHR Object Identifiers (OIDs)](732).

**Emergency Now**: Turn on/off temporary [EHR Emergency](733) access.

---

**EHR Settings**

In the [Main Menu](592), click Setup, [Chart](298), [EHR](709), then click [Settings] in the upper left corner.
EHR settings include meaningful use (MU) stage options, drug interaction severity levels, and default encounter and pregnancy diagnosis codes used in CQMs. These settings should be defined prior to entering patient data for MU.

**Global Settings**

**Only show high significance Rx alerts:** Determine whether less severe Rx / Prescription Alert (1267) show when writing paper prescriptions in Open Dental. High significance alerts always show.
- Check the box to only show severe/high significance alerts.
- Uncheck the box to show all alerts, regardless of severity level.

**Automatically send Summary of Care webmails:** Determines if Secure WebMail Feature about summaries of care are automatically sent to patients when a referral is made to another provider.
- Check the box to automatically send patients a summary of care WebMail when a referral to another provider is made.
• Uncheck the box to not send patients an automatic summary of care WebMail when a referral is made.

Select the stage of meaningful use to apply to provider's whose EHR Meaningful Use setting is Use Global (Provider(1255)). Stage determines which measures list on the EHR dashboard and in Measure Reports. There are three options:

<table>
<thead>
<tr>
<th>Stage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Modified Stage 2</td>
</tr>
<tr>
<td>Stage 1</td>
</tr>
<tr>
<td>Stage 2</td>
</tr>
<tr>
<td>Modified Stage 2</td>
</tr>
</tbody>
</table>

**Modified Stage 2** (this should be the setting for all providers entering meaningful use data.)

Stage 1 and Stage 2 can be used for historical information.

**Default Encounter Code**

By setting a default encounter code, you ensure that an Encounter(425) (based on the code) is automatically generated every time a procedure is set complete. Only one encounter per date/patient/provider combination will be generated. So if a patient has procedures completed on one day, one by a dentist and one by a hygienist, an encounter will be generated for each provider.

You are not limited to the recommended codes and can choose your own SNOMED CT codes, CDT(1198) codes, CPT Codes or HCPCS code. However, if you choose a code not in the recommended list, patients may not be included in CQM calculations if the code does not qualify. If you do not select a code at all, encounters must be manually created in order to affect CQM calculations.

**Recommended Codes:** These 9 SNOMED CT codes are used in every CQM. Click the dropdown to select. A description will show.

- none: Encounters will NOT be automatically generated.
- 90052600: Initial evaluation and management of healthy individual (procedure)
- 185349003: Encounter for check-up (procedure)
- 185463005: Visit out of hours (procedure)
- 185465003: Weekend visit (procedure)
- 270427003: Patient-initiated encounter (procedure)
- 270430005: Provider-initiated encounter (procedure)
- 308335008: Patient encounter procedure (procedure)
- 390906007: Follow-up encounter (procedure)
- 406547006: Urgent follow-up (procedure)

**Insert Encs:** Generate encounters for a code for a date range. For example, you would generate codes if you did not select an encounter code before your reporting period. See [Generating Encounter Codes](715).

**Default Pregnancy Diagnosis Code**

Pregnancy codes exclude patients from some Clinical Quality Measures (CQMs). The default pregnancy code is used automatically when you exclude a patient from a vital signs BMI exam due to pregnancy. A diagnosis of pregnancy will also be added to the patient's list of problems with a start date equal to exam date, if an active diagnosis already doesn't exist in the list.

You are not limited to the recommended codes and can choose your own SNOMED CT, ICD-9-CM, or ICD-10-CM code. However, if you choose a code not in the recommended list, or choose no code at all, you must manually enter pregnancy diagnosis with a qualified code to exclude a patient from CQM calculations.

**Recommended Codes:** These 9 SNOMED CT codes are used in CQMs. Click the dropdown to select. A description will show.

- none: Pregnancy codes will NOT be automatically generated
- 72892002: Normal pregnancy (finding)
- 77386006: Patient currently pregnant (finding)
- 83074005: Unplanned pregnancy (finding)
- 169560008: Pregnant - urine test confirms (finding)
- 169563005: Pregnant - on history (finding)
- 169565003: Pregnant - planned (finding)
237238006: Pregnancy with uncertain dates (finding)
248985009: Presentation of pregnancy (finding)
314204000: Early stage of pregnancy (finding)

**EHR Default Encounter Code**

Set a default encounter code before your EHR reporting period to automatically generate an EHR Encounter (425) (based on the code) every time a procedure is set complete. Encounters affect the denominator of EHR Clinical Quality Measures (418). If you do not select a default code (none) no encounters will be created, and CQM values will be zero.

- We recommend selecting one of nine SNOMED CT codes that are used in every CQM, thus increasing the number of encounters eligible for inclusion in CQM calculations.
- If you choose a code not in the recommended list, patients may not be included in CQM calculations if the code does not qualify.
- If you do not select a code at all, CQM values will be zero, though you can manually create encounters or use the Encounter Code Tool (715) to automatically generate encounters for a date range.

1. In the main menu, click Setup, Chart, EHR (709), then click Settings in the upper left corner to open the EHR Settings (711) window.
2. In the Default Encounter Code area, select the code.

To select a recommended code, click the dropdown and select it.
- 90052600: Initial evaluation and management of healthy individual (procedure)
- 185349003: Encounter for check-up (procedure)
- 185463005: Visit out of hours (procedure)
- 185465003: Weekend visit (procedure)
- 270427003: Patient-initiated encounter (procedure)
- 270430005: Provider-initiated encounter (procedure)
- 308335008: Patient encounter procedure (procedure)
- 390906007: Follow-up encounter (procedure)
- 406547006: Urgent follow-up (procedure)

To select a different code (SNOMED CT, CDT, CPT, or HCPCS), click the corresponding button, then select the code. Codes must downloaded before they can be selected. See Importing Code Systems (726). Note that if you choose a code not in the recommended list, patients may not be included in CQM calculations if the code does not qualify.

If you select none, EHR Encounters (425) will not be automatically generated. You must do it manually.
3. Click OK to save selections.

Only one encounter per date/patient/provider combination will be generated. So if a patient has procedures completed on one day, one by a dentist and one by a hygienist, an encounter will be generated for each provider. Also see EHR Default Pregnancy Code (717).

**EHR Generate Encounter Codes**

If you do not set a default encounter code, your EHR Clinical Quality Measures (418) (CQM) encounters will be zero. To automatically generate encounters based on completed procedures, use the Insert Encs tool.

Note: We recommend setting a default encounter code before you start a reporting period so CQM encounters are created every time you complete a procedure. See EHR Default Encounter Code (714).

1. In the Main Menu (592), click Setup, Chart, EHR (709), then click Settings (711) in the upper left corner.
2. Click **Insert Encs**.
3. Enter a start and end date for the date range.
4. Click Run.

You will see a note of the number of encounters inserted and your CQM denominators will be changed.

**EHR Default Pregnancy Code**

Pregnancy codes exclude patients from some EHR Clinical Quality Measures (CQMs). The default pregnancy code is used automatically when you exclude a patient from a EHR Vital Signs (BMI) exam due to pregnancy. A diagnosis of pregnancy will also be added to the Problems list with a start date equal to exam date, if an active diagnosis already doesn't exist in the list.

- We recommend selecting one of nine SNOMED CT codes that are used in CQMs as exclusion criteria.
- If you choose a code not in the recommended list, or select none, you must manually enter pregnancy diagnoses with a qualified code to exclude a patient from CQM calculations.

1. In the Main Menu (592), click Setup, Chart, EHR (709), then click Settings (711) in the upper left corner to open the EHR Settings window.
2. In the Default Pregnancy Diagnosis Code area, select the code.
To select a recommended code, click the dropdown and select it.

- 72892002: Normal pregnancy (finding)
- 77386006: Patient currently pregnant (finding)
- 83074005: Unplanned pregnancy (finding)
- 169560008: Pregnant-urine test confirms (finding)
- 169563005: Pregnant-on history (finding)
- 169565003: Pregnant-planned (finding)
- 237238006: Pregnancy with uncertain dates (finding)
- 248985009: Presentation of pregnancy (finding)
- 314204000: Early stage of pregnancy (finding)

To select a different code (SNOMEDCT, ICD9CM, or ICDD10CM) click the corresponding button, then select the code. Codes must downloaded before they can be selected. See Importing Coding Systems(726). You will need to manually enter pregnancy diagnosis with a qualified code to exclude a patient from CQM calculations.

If you select none, you will need to manually enter pregnancy diagnosis with a qualified code to exclude a patient from CQM calculations.

3. Click OK to save selections.

Also see EHR Default Encounter Code(714).

EHR Vaccine Setup

In EHR(709), click Vaccine Def.
EHR Vaccine Data(451) must be defined before vaccines can be entered for patients.

Note: Before vaccines can be defined, you must import CVX codes (see Importing Code Systems(726)) and set up EHR Vaccine Drug Manufacturers(719).

Click Add, or double click an existing vaccine to edit.

Enter the vaccine information.
1. Click [...] to select a CVX code.
2. Enter the Vaccine Name.
3. Click the drop down arrow to select the EHR Vaccine Drug Manufacturers(719).
4. Click OK to save.

EHR Vaccine Drug Manufacturers
In the Main Menu(592), click Setup, Chart, EHR(709), then click Drug Manufacturer.
Drug manufacturers must be set up before you can set up Vaccines (451).

Click Add, or double click an existing manufacturer to edit.

Enter the Manufacturer Name and MVX Code, then click OK to save.


### EHR Vaccine Drug Units

Drug units must be set up before you can enter a patient vaccine.

In the Main Menu (592), click Setup, Chart, EHR (709), then click Drug Unit.

Click Add, or double click an existing unit to edit.
Define the drug unit.
- **Unit Identifier**: Enter a unit that matches a valid UCUM code. Measurements will be validated against UCUM codes before vaccine data is exported.
- **Unit Text**: Enter text to describe the drug unit.

Click OK to save.

### EHR Reminder Rules

Reminder rules for [Patient Reminders](#) are optional. A patient does not need to meet a specific rule to document that a reminder has been sent. The rules define criteria a patient must meet for a reminder to show in their Reminder window. Criteria can be based on problems, allergies, medications, age, gender, or lab results.

1. In the [Main Menu](#), click Setup, Chart, [EHR](#), then click **Reminder Rules**.

![Reminder Rules](image)

All rules currently defined are listed.

2. Click Add, or double click a rule to edit.
3. Select the criteria that a patient must meet for a reminder to list in their Reminder window.
   - **Reminder Criterion**: Select the category this rule applies to. There are six choices: Problem, Medication, Allergy, Age, Gender, Lab Result.
   - **Criterion Value**: Enter the value that will trigger the reminder. Less than &lt; and greater than &gt; symbols are allowed. This field only is visible for Age, Gender (male or female) and Lab Results rules.
   - **Medication**: Click [...] to select a medication from the Medications List(1246). This field is only visible for Medication rules.
   - **Allergy**: Click [...] to select an allergy from the Allergy List(1221). This field is only visible for Allergy rules.
   - **Problem**: Click [...] to select a problem from the Problem List(1250). The associated ICD-9 code will also show. This field is only visible for Problem rules.
   - **Reminder Message**: Enter the reminder message.

4. Click OK to save the reminder rule.

---

**EHR Setup Education Resources and Triggers**

Education resources are triggered for a patient based on problems, medications, lab results, or tobacco use status. When a patient meets a defined criteria, the resource can be generated, viewed, and printed. See EHR Educational Resources(411).

1. In the **Main Menu**(592), click Setup, Chart, EHR(709), then click Educational Resources.

All existing education resources will list, along with the criteria that triggers it.

2. Click Add, or double click an existing resource to edit.
3. Define the condition that must be met to show this resource for a patient.
   - **Problem**: Click […] to select a problem from the Problem Master List. The associated ICD-9 and SNOMED CT codes will also show.
   - **Medication**: Click […] to select a medication from the Medication Master List.
   - **Tobacco Use Assessment**: Click […] to select a SNOMED CT code that matches a tobacco use status entered on the Tobacco Use window.
   - **Lab Results**: Enter the ID, Test Name and Value.
   - **Resource URL**: Enter the path used to access the educational resource. It can be a full URL path (http://www.example.com) or a full document path (C:\resources\resources.doc).

In the example above, if a patient’s has ‘bad breath’ in their Problem List, the resource and link will list on the Education Resources window.

4. Click OK to save.

To create more than one reference to the same resource, add separate resources, each with a different condition, and point them to the same URL. For example, reference the same brochure on analgesics when a patient is prescribed ibuprofen, aspirin, or acetaminophen(paracetamol).

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**EHR Annual Provider Keys**

An annual EHR Provider Key allows a provider to access EHR Measure Reports(434). Provider keys are tied to the first and last name of the provider and to the reporting year. Provider keys are supplied by technical support once an EHR contract is signed for the current year. Annual keys replace quarterly keys.

- **Note**: Annual EHR provider keys can be managed from a central location beginning in version 14.3. When you update to version 14.3, provider keys already entered in Open Dental will be transferred automatically.
- See Open Dental EHR for the Medicaid Purchase Form and additional information.
1. In the Main Menu (592), click Setup, Chart, EHR (709).
2. On the EHR Setup window click Provider Keys.

3. Click Add to enter a new key, or double click to edit.

4. Enter the information supplied to you from technical support.
   - **Last/First Name**: These names must exactly match the provider's name on the EHR contract, which should match the provider's name in the Providers (1252).
   - **Year**: Enter the last 2 digits of the reporting year.
   - **EHR Key**: Copy and paste the key provided by technical support.
5. Click OK to save.
EHR Quarterly Keys
Quarterly keys were used in version 13.2 and earlier for EHR Measure Reporting. In versions 14.2 and greater, Annual EHR Provider Keys allow access to EHR reporting.

- If after July 1, 2014, you need to view historical EHR reports, you will need to Update to version 14.1 or greater. This will allow you to access 2013 EHR reports and enter EHR data without any keys.
- To run 2014 EHR reports, you will need to be in a 2014 EHR contract with Open Dental and running version 14.2 or greater. We will then provide you with a new annual provider key for 2014. Older versions of Open Dental do not have the 2014 certification that is required for EHR reporting.

Contact an Open Dental EHR specialist if you have any questions.

Enter Quarterly Keys
In version 13.2 and earlier, in the Main Menu, click Setup, Chart, EHR, Quarterly Keys.

Click Add.
Enter the year, quarter, and the key.

- **Year:** The last two digits of the current year (2013 = 13).

- **Quarter:** Jan. - Mar. = 1, Apr. - June = 2, July - Sept. = 3, Oct. - Dec. = 4

- **Key:** The quarterly key given to you by technical support.

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**Importing Code Systems**

In the [EHR Setup Window](#), click Code Systems Importer.

Several systems for medical and procedural coding can be imported into Open Dental and then attached to patient information. Coding systems allow a consistent way to organize, index, store, and retrieve clinical data between providers and care sites. EHR must be turned on in [Show Features](#) (806) to access this areas.

EHR: Some data must be associated with a specific code to be recognized in [EHR Measure Reports](#) (434), or to show in clinical documents. We recommend importing all code systems. At a minimum, import [RxNorms](735), [SNOMED CT Codes](727), and [LOINC Codes](728), since these code systems are used often in EHR data. [CPT Codes](734) are not required for EHR and must be purchased separately.
Note: Code systems cannot be downloaded when using Middle Tier. Instead, connect directly to the database.

Click Check for Updates. A list of code systems available for import will list.

- **Code System**: The code system name. A description of each is below.
- **Current Version**: If you have downloaded a coding system, the version downloaded shows.
- **Available Version**: The latest version of the coding system available to download.
- **Download Status**: Indicates the status of download and the number of codes imported.

Select the code system(s) to import. Click and drag, or press Ctrl while clicking to select multiple systems.

(optional) To retain previously downloaded code descriptions, check the Keep old descriptions box. To replace old descriptions with new, uncheck the box.

Click Download Updates.

If there are licensing agreements, they will display prior to import. Click OK to agree to licensing terms and proceed; click [X] to cancel the import.

It may take a several minutes for the data to download. As the download progresses, the status will show in the Download Status column. When the import is complete, a message will indicate success. The download is not complete until the message shows.

![RXNORM codes imported successfully.](image)

**Available Coding Systems**
Currently the following coding systems can be downloaded. This table has been ommitted.

**SNOMED CT Codes**
In the [EHR Setup Window](709), click **SNOMED CTs**.
SNOMED CT codes are a standardized clinical health coding terminology. For EHR, every problem in your master list must be assigned a SNOMED CT code. This will ensure that medication reconciliation and clinical decision support interventions work correctly, and that problems show on a patient's clinical documents (e.g. EHR Continuity of Care Document (CCD) (414)).

To import SNOMED CT codes, see Importing Code Systems (726). In version 14.2.9 or greater, SNOMED CT codes are available to all U.S. customers with a current registration key.

When first opened the list will be empty. Enter the first few characters of the description or code, then click Search to filter results.

If the user has the Show iCDS permission (EHR CDS Permissions (731)), the EHR InfoButton (428) will show in the first column. If the code is used in EHR Clinical Quality Measures (418), the number of the CQM is listed.

To associate a SNOMED code with a Problem open the Problem List (1250), double-click on an existing problem, or Add a new one, and select the SNOMED CT code from the pick list (...).

Map to ICD9: This is a one time tool that can be used to map a SNOMED CT code to an existing problem, if that problem has an ICD-9 code that correlates to exactly one SNOMED CT code. If there is any ambiguity, the code will not be added to the problem. The button only shows if you are logged in as a user associated to a provider with a valid EHR provider key.

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LOINC Codes
To import LOINC codes, see Importing Code Systems (726).
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LOINC codes (Logical Observation Identifiers Names and Codes) is a standard for identifying medical laboratory observations. They are used in CQMs, laboratory and radiology orders, clinical summaries, summaries of care, and when validating syndromic surveillance and vaccine data. LOINC codes are only available for US customers.

To view imported LOINC codes, click LOINC on the [EHR Setup Window](709).

To select a LOINC code, click [...] to pick from a list.

**Code or Description**: Enter characters to filter the list, then click Search. Select a code and click OK.

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**EHR Configure CDS Rules**

In the [Main Menu](592), click Setup, Chart, [EHR](709), then click [CDS Triggers](410).

**Clinical Decision Support** rules (CDS) rules determine what conditions trigger [EHR CDS Interventions](410). Conditions can be problems, medications, allergies, age, gender, vital signs, lab results, and/or specific codes.

Users must have the [Edit CDS Permission](731) to configure interventions.

Click **Add** to create a new intervention or double click an existing intervention to edit.
Enter the Description of the intervention.

Click the Cardinality down arrow and set when the CDS support intervention will be triggered:

- One: only one condition must be met.
- One of each category: One condition from each category must be met.
- Two or More: At least two of the conditions must be met. Does not work with Vital Signs, Age or Gender.
- All: Every condition selected must be met.

Click a button on the left of the window to define the condition(s) that will trigger the CDS intervention. There are 6 categories:

- **Problem**: Triggered by Problem, ICD-9 or ICD-10 code, or SNOMED CT code.
- **Medications**: Triggered by Medication, RxNorm, or CVX code.
- **Allergies**: Triggered by Allergy name.
- **Demographics**: Triggered by Age or Gender. For age, enter the operand and value (e.g. &gt;18). For gender, enter female, male, or unknown.
• **Lab Results**: Triggered by specific lab results.
• **Vital Signs**: Triggered by height, weight, or BMI. Enter the operand and value. - For height, enter inches (\(\geq 60\)). - For weight, enter lbs (\(< 100\)). - For BMI, enter percentage (\(\geq 27.5\%\)).

**Instructions**: Enter clinical, diagnostic or therapeutic guidance.

**Bibliography**: Enter reference information.

Click OK to save.

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**EHR CDS Permissions**

In the [Main Menu](592), click Setup, Chart, EHR, then click **CDS Triggers**. In the upper left corner, click **Setup**.

![EHR CDS Permissions](image)

In Clinical Decision Support (CDS) setup, you can grant or block specific users from [EHR Configure CDS Rules](729) or encountering [EHR CDS Interventions](410).

All users set up in Security will be listed, along with a column for each permission area. The Admin user always has the ability to view this window.

Click in a column to allow or block a user from a permission. An X in a cell indicates the user has permission. This table has been omitted.

---

**EHR NIST Time Synchronization**

Open Dental has the ability to check and synch times with a NIST time server within 1 second. The check and synchronization is not automatic and we do not verify that it happens. This process checks local and database times for synchronization and verifies that all dates and times of [Audit Trail](1424) entries are exact and accurate. Time synchronization was a certification requirement for [EHR](709). If you do not use Open Dental for time synchronization, you should synchronize time another way.
We recommend you run Open Dental on the server (where the MySQL database is). Then Open Dental will check and synch times before you log on and every four hours thereafter. You do not need to log in to Open Dental for the synch to occur.

If you are running Open Dental on a different machine (not the server), you can manually check and synch times.

In the **Main Menu** (592), click Setup, Chart, EHR, then click **Time Synchronization**.

![Time Synchronization](image)

The specific times for each server are listed. If Open Dental is unable to connect to the NIST time server, the operation may time out.

**Synch Time**: Check the NIST server time and synchronize all server times to match. You are limited to checking once every four seconds so the NIST server is not spammed with requests.

Sometimes a difference in server times is harmless. In order for your times in Open Dental to be accurate, it is best to have both your server and local time in sync with an NIST time server. If you have concerns, please contact us.

**Troubleshooting**
**Error: Time out of synch**
Solution: Make sure Open Dental is running on the server.

**Error: No response received**
Solution: This is a timeout response from the time server. It may happen intermittently due to the nature of the message and sending a UDP packet over the internet. If this is happening fairly often, there may be something stopping the time request messages from getting to the destination (e.g. Firewall).

**EHR Object Identifiers (OIDs)**

Object identifiers are global unique identifiers used when sending or exporting [EHR Continuity of Care Document (CCD)](https://www.ncbi.nlm.nih.gov/books/NBK523318/) (414), medical lab orders, or [EHR Clinical Quality Measures](https://www.ncbi.nlm.nih.gov/books/NBK523318/) (418). It uniquely identifies a patient in the database. OIDs are made up of the Root + Type identifier.

1. In the **Main Menu** (592), click Setup, Chart, **EHR** (709), then click **Internal OID Registry**.
2. To determine your Root OID you have two options:
   - Use a unique OID based on Open Dental's OID and your registration key. Click Retrieve OIDs and each value will automatically populate.
   - Obtain and enter your own unique root OID. Visit https://www.hl7.org/oid/index.cfm to register and obtain an OID. Enter it on the OID window in the Actual Value column.

If you have multiple databases that use the same Open Dental registration key, you must manually assign a unique root OID to each database. We recommend retrieving an unique OID for your registration key, then inserting a unique identifier for each database at the end of the root. For example: This table has been omitted.

3. If you manually entered a root OID, enter the Actual Value for each type. If you Retrieved OIDs and did not change any values, this step is done automatically.

   The values you use are up to you, but we recommend the following:

   **Root**: The database's Root OID
   **LabOrder**: Root OID + an identifier for lab orders (We recommend adding .1 to your root)
   **Patient**: Root OID + an identifier for patient (We recommend adding .2 to your root)
   **Provider**: Root OID + an identifier for provider (We recommend adding .3 to your root)
   **CqmItem**: Root OID + an identifier for CQM (We recommend adding .4 to your root) This table has been omitted.

4. Click OK to save.

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**EHR Emergency**

The Emergency Now button on the EHR Setup(709) window toggles emergency mode on and off. Anyone can switch to emergency mode.

When emergency mode is turned on, the box next to the button turns red, and users with the EHR Emergency Access security Permission are given temporary access to other permissions. For the very narrow requirements of EHR
certification, this permission currently gives access to the Family Module (59) (FamilyModule), which is a permission most users have anyways.

CPT Codes
Current Procedural Terminology (CPT) codes are five digit numeric codes used to describe medical procedures and physician services. They are maintained and distributed by the American Medical Association (AMA).

CPT codes were only used when offices could participate in EHR (709). CPT codes were optionally used for CQM Encounters, Reasons not Performed, Vital Signs, and Smoking Cessation Interventions. Codes had to be purchased from the AMA store for use.

While CPT codes can be imported, they do not and cannot show in the Procedure Code List.
CPT codes must be manually added and, if desired, cross coded to procedure codes. See Cross Codes (734) and Medical Insurance (128)

Cross Code
Medical CPT Codes (734) can be cross coded to dental Procedure Codes (1195). Then, when a Medical Claim (128) is created for the procedure, the Medical (466) code is used on the claim instead of the dental code. Cross coding does not affect what shows on EHR Continuity of Care Document (CCD) (414).

Medical codes can be added one at a time (Add Procedure Code (1204)) or using the Code Import Tool (726). As you add the codes, optionally set the Category to Medical Code. If that category doesn't exist, you can add it in Definitions: Proc Code Categories (883).

In Procedure Codes, double click the new medical code to open the Procedure Code (1200).

Leave the Medical Code field blank.

In the Procedure Code List, double click the dental procedure code.
Enter the medical code (CPT code) in the Medical Code field to complete the cross coding.

RxNorms
RxNorm is a normalized naming system for generic and branded drugs.

In the EHR Setup Window (709), click RxNorms.

Alternatively, RxNorms may be assigned to Medications (1246) using a pick list [...].

Drug names include active ingredients, strength, and form. All medications in your master list must have an RxNorm assigned for medication reconciliation, clinical decision support interventions, and Open Dental's drug interaction alerts to work correctly. This will also ensure a patient's medications show on clinical documents (e.g. EHR Continuity of Care Document (CCD) (414)).

To import RxNorms see Importing Code Systems (726).

Search for the drug, highlight it, then click OK.
Code or Description: Enter the code or description. Click Similar to return all results that closely match; click Exact to only return results that exactly match all entered text.

Ignore Numbers: Only search letters found in descriptions and ignore any numbered measurements.

None: Clear the RxNorm drug selected on the previous screen.

Procedure Buttons
In the Main Menu(592), click Setup, Chart, Procedure Buttons.

Procedure buttons allow you to quickly add your most common procedures to a patient's chart with a single click. They are located in the Chart Module(298) on the Enter Treatment(301). Usually you will simply click on a tooth, then click a procedure button to chart the treatment.

There are two types of procedure buttons:

- Quick Buttons: Designed to quickly chart fillings and sealants on teeth. Each quick button can be associated with one procedure, and if applicable, to tooth surfaces.
- Other Procedure Buttons: Can be associated with multiple procedure codes and Auto Codes(813).

By default, procedure buttons are associated with D-Codes.

Webinar: Procedure Buttons, Quick Buttons, and Auto Codes.
**Set up quick buttons**

To edit an existing quick button, double click on it. To add a new quick button, double click in the right panel (white area under **Buttons for the selected category**) on the location where you want it to show.

Enter the button information.
- **Display Text**: The button text.
- **Procedure Code**: Enter the procedure code that will be applied when this button is clicked. Click [...] to select from the **Procedure Codes** (1195). Only one code can be associated per quick button and it must exist in the prior to setting up the quick button.
- **Surfaces**: Enter the surfaces that will be applied when the button is clicked (B/F, V, M, O/I, D/L).
- **Display as Label**: Check this box to display the text as a label instead of a button. This text will not be click-able in the Chart Module.

Click OK to save.

Hints:
- **Layout**: New buttons are always placed to the right of the last button in the row. To add a space between buttons, create a blank button with no text, code, or surfaces, and check **Display as Label**.
- **Surfaces**: Any text can be entered for the surface, but Open Dental will validate the surface before applying to the procedure. For example, if a surface of MOPDL is entered, Open Dental will validate it to MODL. Validation will occur left to right and exclude any non-valid surfaces.

**Set up other procedure buttons**

Other procedure buttons are grouped into categories (e.g. General, Exams/Cleanings, Fillings, etc.).

1. In the Main Menu, click Setup, Chart, Procedure Buttons.
2. Click on a category to see its procedure buttons.
The procedure buttons listed above are the default. To restore to the defaults, run Procedure Code Tools (1198) for Procedure Buttons.

To rename, reorder, or add new categories, click Edit Categories to access Definitions: Proc Code Categories (883).

To reorder buttons within a category, use the Up and Down arrows.

3. Click Add or double-click a button to edit.
4. Enter general button information:
   - **Description**: The button name.
   - **Category**: Click the dropdown to select the button category.

5. Select an image to associate with the button. The current image appears to the right of Image (20x20). There are three options:
   - Pick an image from the list on the right.
   - Click Import to select an image file on your computer. Images should be 20x20 pixels. Additional icons may be available in the User Forum.
   - Click Clear to remove the current image.

6. **Group for multiple visits**: Check this box if the procedures on this button should be grouped for multiple visits (e.g. crowns). When procedures are grouped, completed procedures will show as a status of Complete (In Process) until all other procedures in the group are completed as well.

7. Add procedure codes to associate with this button. Click Add to add a new code from the Procedure Code List. Click Delete to remove a code.

8. Highlight any auto codes to associate with this button. To select multiple auto codes, press Ctrl and click on the codes to highlight.

9. Click OK to save the button.

Example of a RCT BU Ceramic procedure button (as shown in screenshot above):
- **Setup**: There are two procedure codes: one ADA code, and one non-ADA code for a crown seat. There are also two auto codes: Root Canal and BU/P&C. Auto codes are used instead of procedure codes because there are several possible ADA codes, depending on the area of the mouth. Each auto code represents one final procedure code, but the code used depends on a number of conditions.
- **Use**:
  - If this button is used for tooth #3, the 4 procedure codes would be Crown Seat, Molar RCT, Build Up, and Crown.
  - If tooth #8 is involved, the 4 procedure codes would be Crown Seat, Anterior RCT, Post & Core, and Crown.

**Procedure button logic**
When entering treatment, you can select multiple teeth before clicking a procedure button. The program will loop through each tooth and repeat the logic.
For example, set up a bridge procedure button:
- Select one non-ADA code for a bridge seat.
- Set an area type of tooth range.
- Select one auto code for bridge with two alternatives: assign a pontic code for missing teeth, assign a retainer code for other teeth.

In the patient's chart:
1. Mark the pontic tooth as an existing extraction as described in Missing Teeth (323).
2. Select all three teeth involved in the bridge and click the bridge procedure button.

Since the bridge seat is a tooth range, the program will know to not add it three times to the chart, but only once with all three tooth numbers selected.

**Quadrants**

Procedure buttons can be used to create four procedures, each with a different quadrant. To trigger this behavior, enter four of the exact same code in the list on the left. For example, D4341, D4341, D4341, D4341. To use, click the procedure button with no tooth selected.

There is no support for a procedure button to create a procedure with a specified quadrant. Instead the quadrant will be assigned based on the tooth selected when the button is clicked. If no tooth is selected, single procedures will default to UR. To trigger this behavior, enter one code in the list on the left. For example, D4341. To use, select a tooth in one or more quadrants and click the procedure button.

You can now also create a Quick Button for a SRP as well (see Quick Buttons above). Create a quick button with SRP in the title, enter D4341 as the code, leave the Surface field blank and click OK. Then select a tooth in the specific quadrant (1,2,3 or all 4 quadrants) and click the Quick Button.

**Images Module Preferences**

In the Main Menu (592), click Setup, Images, Images Preferences.

Alternatively, click Setup, Module Preferences (927), Images tab.

Here you can set default options and settings for the Images Module (480).

These options determine the default setting for the document tree (expanded or collapsed). There are three options; choose one.

- **Expand the document tree each time the Images module is visited**: Every time the Images module is opened, tree view is expanded to show all documents in each folder.
- **Document tree collapses when patient changes:** Each time a user switches patients, tree view is collapsed to show only folders, not the documents within.
- **Document tree folders persistent expand/collapse per user:** Whether folders are expanded or collapsed is based on the user's last view. If a specific folder is marked as *Expanded by default* in Definitions: Image Categories, it will always be expanded, unless the user has manually collapsed it.

**Imaging Quality**

In the [Main Menu](#), click Setup, Images, Imaging Quality.

![Imaging Quality Interface](image)

These are the default settings used when scanning forms, letters, photos or radiographs in the [Images Module](#), or
capturing images using Suni(1066). Settings only apply to the computer you are working on. Also see Scanning(484) and Scanners.

Set Default Scanner: Click to select the scanner that will be used as the default each time you scan.

Documents
These settings are for scanning single documents and multi-page documents in the Images module.

Show Select Scanner Window: Check this box to select the scanner every time you scan. The option selected will also apply when you click Scan Radiograph or Scan Photo in the Images module toolbar.

JPEG Compression - Quality After Scanning: Set the image quality (0 – 100) for the file that is saved in the A to Z Folder(826). A lower number means more compression and smaller file size. 100 = no compression 0 = maximum compression. A typical setting is 40.

Show Scanner Options Window: Select this option to open the scanning device window to select scanning options every time you scan. We recommend this option so you can customize scan settings.

Use the Options Below: Select this option to use the default scanning options every time you scan, instead of opening the scanning device window. The option selected will also apply when you click Scan Radiograph or Scan Photo.

If you select Use the Options Below, the options set below will be used.
- Multipage Scans Duplex: Scans both sides of documents when checked. Scans one side of documents when unchecked.
- Grayscale: Scans in grayscale when checked. Scans in 24-bit color when unchecked.
- Resolution: The dots per inch (dpi) of the document that is collected from the scanner. Must be at least 51 dpi.

Recommended Scanning Settings:
- Documents: 150 dpi.
- Photos: color, 300 dpi.

Radiographs
Set the default pixel windowing values to use when scanning radiographs. A slider is also available in the Images module to adjust pixel windowing for individual radiographs. Windowing is useful for images like radiographs because it isolates changes in gray levels. For more details, see Enhancing Radiograph Images(742).

Recommended Scanning Settings:
- Panos: grayscale, 300 dpi.
- BWs: grayscale, 400 dpi.

Photos
Recommended Scanning Settings: color, 300 dpi.

Suni Imaging
The Suni Imaging boxes at the bottom are for adjustments needed by Suni sensors.

Exposure Level: Select a value between 1 and 7.

Sensor Port: Set to 0, unless you have a problem capturing. If you change the port number to 1, be sure to stop any current image captures first, or simply restart Open Dental to ensure that the new settings take effect.

Sensor Type: Enter the last letter of the Suni CCD serial number. Open Dental only supports sensors ending in B or D.

Binned: Refer to your Suni documentation for explanation of this option.

Enhancing Radiograph Images
A raw image, such as a radiograph, may need to be adjusted to make it easier to see a specific feature such as caries or an abscess. You cannot do this with a film radiograph, and this is a major advantage of using digital radiographs.

This page discusses some of the terminology used when scanning or viewing digital radiographs. To scan radiographs, see the Images Module(480). To set default scanning values, see Imaging Quality(741).

**Pixels**
An image is made up of many pixels, or dots. Each pixel can have a value between black (0) and white. The numeric value of white depends on the situation. If you are using 8 bits, white is 256, or for 12 bits, white is 4096. In the examples below, we use 1 as the value for white, with the various gray levels between 0 and 1.

Below is a graph representing no enhancement. The x axis represents the color (gray level) of each pixel input from the raw image, and the y axis represents the resulting output in the enhanced image. As you can see, for any value that is input, the exact same value will be output. The red shows how an input of .5 results in an output of .5. So this graph is the basis against which all enhancements will be compared.

**Contrast and Brightness**
Contrast is the steepness of the line; the steeper the line, the more contrast. Brightness is represented by a horizontal shift in the line without changing the contrast.

**Gamma**
Gamma is the curve in the line. It is input to the power of the gamma value, or f(x)=x^gamma. Enhancing an image with gamma results in a pleasing appearance because the human eye perceives color in a non linear manner. A gamma of 2.2 is shown in the graph below. An input pixel value of 0.5 results in an output of 0.22. So overall, the image is a little darker, and in the lighter range, there is more contrast as shown by the steeper part of the curve. CRT monitors usually have a little too much gamma (2.5) due to technical limitations, and the images need to have the gamma adjusted down, either through hardware or software. LCD monitors have a somewhat irregular output curve. Gamma is more useful in color photos than in black and white images like radiographs.

**Windowing**
Windowing is an alternative to contrast and brightness that is very useful for images like radiographs.
This is the Open Dental slider control that lets the user set the windowing values (Imaging Setup, Images module):

The line is steeper (more contrast) over a specific range of input values. This results in a smaller window of values which are spread into the output so they can be seen more easily. A window has a lower bound and an upper bound. All input values below the lower bound are output as black, and all values above the upper bound are output as white. This is a wonderful way to enhance a radiograph because you are usually interested in very subtle changes in a small range of gray values. Moving the window left and right isolates the gray levels you are interested in. The slider should affect the entire image in real time for it to be useful.

**Contrast Limited Adaptive Histogram Equalization**
This is an automated way of enhancing the contrast and brightness. A histogram is simply a count of how many pixels are in the image for each grayscale level. If the image is too dark or too light, then this technique will shift the pixels towards a more neutral shade. And if there is not enough contrast, then it will spread out the shades similarly to windowing. But it's all automated and based on localized regions of the image rather than just treating the image as a whole. This technique is used by Schick and a few others. It is not used by Open Dental.

**Manage Module Preferences**
In the Main Menu(592), click Setup, Manage, Manage Preferences.
Alternatively, click Setup, Module Preferences (927), Manage tab.

Set default options and settings for features in the Manage module. To enable a preference, check the box or uncheck the box to disable.

Send all new prescriptions to electronic queue: Only added for 2011 EHR certification.

Time Card first day of week for overtime: If using time cards, set the first day of the week used to calculate weekly overtime (over 40 hours). See Time Card Setup (773).

ADP Export includes employee name: Select whether or not to include employee names when exporting time card data in ADP format. This information is not needed by ADP, but may make output more readable.
- Checked: Include employee names.
- Unchecked: Do not include employee names.
Claim Send window validate on load (can cause slowness): Select when to validate e-claim information on the Insurance Claims window (Send Claims(489)).
- Checked: Open Dental will validate e-claim information when the Insurance Claims window is loaded. When using Clinics this option can cause slowness.
- Unchecked: Open Dental will validate e-claim information when sending.

Select all provider/employees when loading schedules: Determines whether providers and employees are automatically selected by default when you open the Schedules window (Schedule Setup(1099)).
- Checked: All providers and employees are highlighted by default when you open the window.
- Unchecked: No providers or employees are highlighted by default when you open the window.

Billing and Statements: The options below affect billing defaults and what shows on Statement(269).

Show return address:
- Checked: Show the practice or clinic address as the return address.
- Unchecked: No return address shows.

Show notes for payments:
- Checked: Notes entered on the Payment(153) window show with any payment entries. These notes always show in the Patient Account Grid in the Account module.
- Unchecked: Notes entered on the Payment window don't show.

Show notes for adjustments:
- Checked: Notes entered on the Adjustment(203) Edit Window show with any adjustment entries. These notes always show in the Patient Account Grid in the Account module.
- Unchecked: Notes entered on the Adjustment window don't show.

Show procedure breakdown:
- Checked: Additional financial information will show in the Description column for each procedure (e.g. patient portion, insurance paid, write-off, adjustment).
- Unchecked: This information will not show.

Account Numbers use: Select whether to use Chart Number or PatNum for the account number.

Days to calculate due date. Usually 10 or 15. Leave blank to show “Due on Receipt”: Enter the number of days that will be used to calculate the Due Date on statements.

Days in advance to bill payment plan amounts due. Usually 10 or 15: Enter the number of days in advance of a payment due date that statements will be triggered to print when running billing. See Payment Plan(239).

Account Module statements default to intermingled mode:
- Checked: Statements generated from the Account module default to intermingle family members (mix patients in the same family together in one grid and sorted by date). Future Appointments for all family members will display on walkout statements.
- Unchecked: Statements generated from the Account module do not intermingle families by default (each patient will have a section on the statement). Only the selected patient's future appointments will display on walkout statements.

Max number of statements per batch (0 for no limit): Enter the maximum number of statements that will be considered a batch when sending statements via the Billing List. Number entered cannot be greater than 256. Enter 0 to set no limit. Will be ignored if using Output to File option in Electronic Billing(514). Useful for large offices that send many statements.

Show progress when sending statements: Determines whether or not a progress bar shows when sending statements via the Billing List.
- Checked: A progress bar does show that includes options for pause, resume, cancel.
• Unchecked: A progress bar will not show.

**Print statements alphabetically:** Only visible when clinics is enabled. Determines order statements are printed.
• Checked: Prints statements in alphabetical order of patient's first and last name, regardless of clinic
• Unchecked: Patients are ordered by clinic, then alphabetically by first and last name.

**Show claims received after days (blank to disable):** Zero dollar insurance claim payments received within the number of days entered will show in the Batch Insurance Payments window (Batch Insurance Payment) when finalizing an insurance check. If left empty, zero dollar insurance claim payments will be hidden.

**Finalize claim payments in Batch Insurance window only:**
• Unchecked: Users can finalize claims from the Claim(208) or the Batch Insurance Payments window.
• Checked: Users can only finalize claims from the Batch Insurance Payment window. They will be blocked from finalizing claims on the Edit Claim window.

**ERAs print one page per claim:** When printing ERAs(568), print one page for each claim listed.

**ERAs post write-offs for Category Percentage and Medicaid/Flat CoPay:** Determines whether write-offs will be posted for Category Percentage and Medicaid/Flat CoPay insurance plan types.
• Checked: Write-offs will be calculated and posted for all plan types, including Category Percentage and Medicaid/Flat CoPay.
• Unchecked: Write-offs will only be posted for PPO and PPO Fixed Benefit plan types.

**Insurance Payments: show auto deposit:** Determines whether or not automatic deposits for claim payments is enabled or disabled.
• Checked: Automatically create deposits when Finalize Insurance Payment(231).
• Unchecked: Do not automatically create deposits.

**Allow paid 30 minute breaks:** Determines whether up to 30 minutes of break time is considered as paid or unpaid on time cards.
• Checked: Count up to 30 minutes of break time as paid time. Enables the View Breaks button in the Manage module and Breaks radio button on the Time Card for employee window. Also enables the Lunch status so employee can clock out for unpaid breaks.
• Unchecked: All break time will be considered as unpaid time. Disables the Lunch status and View Breaks button in the Manage module. Also disables the Breaks radio button on the Time Card for employee window.

**Note:**
Before changing this preference, have all employees clock out and make any needed time card adjustments. Changing the preference will not affect historical time card breaks. Breaks that occur while the preference is checked will remain as paid breaks. Breaks that occur when the preference is unchecked will remain as unpaid breaks.

**ERA allow total payments:** Determines if procedure level payment splits are required when processing ERAs(570).
• Checked: Payments can be added as total.
• Unchecked: Payments must be allocated to procedures.

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**Email Setup**
In the MainMenu(592), click Setup, Manage, Email.
Alternatively, in the Email Inbox (561), in the top menu, click Setup.

You can have one outgoing email address per clinic. Add the clinic email address here, then assign it in the Clinic Edit (1224) window.

WebMail (1672) and Email Encryption Options (1662) are more secure options.

Email Addresses: A list of email addresses that can be used by all staff members (e.g. general practice, clinic, or group email addresses).
- User Name: The email address.
- Sender Address: The Email address of sender as entered on the Edit Email Address window.
- User: The user associated with the email address.
- Default: The email marked X is the default From email for outgoing emails.
- Notify: The email marked X is the From email used to send secure WebMail notifications to patients.

Double-click to Edit Email Address (599).

Set Default: Set the selected email address as the From email address for outgoing emails (if a user-specific email is not entered).

WebMailNotify: Set the selected email address as the From email address for WebMail notifications to patients.

Note: Default and WebMail Notify email addresses are required for eServices (1510) to function correctly.

Add: Add a new email address that can be used by all staff members.

Inbox Receive Interval: Set the time, in minutes, to automatically check for and download new emails using Open Dental Service (1415). Five minutes is the default.

Include Opt-Out Statement: Determines if an opt-out statement is included in eService emails. The statement includes Practice (931) or Clinic (1223) address and instructions about how to unsubscribe from eService emails (see example below). The statement is only included in emails sent for Web Sched ASAP (1594), Web Sched Verify (1606), Web Sched Recall (1600), eConfirmations (1620), eReminders (1613), Patient Portal Invites, the Confirmation List (35), and the Recall List (27).
- Checked: Include the opt-out statement at the bottom of all eService emails. The opt-out statement cannot be edited.
- Unchecked: Do not include the opt-out statement in eService emails.

Example:
This email has been sent to you from:

North Clinic
123 Walrus Way
Portland, OR 97338.

How to unsubscribe:

If you no longer want to receive any email messages from us, simply reply to this email with the word "unsubscribe" in the subject line.

Note: When a patient emails a response to unsubscribe, they are not automatically removed from an eService email list. To stop sending them eService emails, remove their email address on Edit Patient Information(62).

See Email Errors(1667) for detailed information on potential errors.

Email Certificate

Email(747) security certificates (digital IDs) are required for sending encrypted email. Each security certificate will be associated with an email address. Below are some services we are aware of that issue email security certificates. Click a link to visit each website:

- Comodo(749) (links to Comodo instructions)
- GlobalSign
- Symantec
- Entrust
- Trustwave

Self-signed certificates: You can also create a self-signed certificate, but these are unlikely to be automatically trusted or discovered by a third party. This means both parties must manually add the certificate to their internal list of trusted certificates. See your Windows documentation for instructions.

Certificates do expire and need to be renewed. A typical certificate life is 18 months, but can be increased to as much as 10 years or more, though security risk is increased.

Once you have obtained an email security certificate, Install Public and Private Keys on a Workstation(761). For Direct Messaging(1666), public keys also need to be installed on a hosting server. See Email Certificate Hosting(759).

Email Certificate Comodo

Below are instructions for obtaining and backing up a Comodo Email Certificate(749) using the Mozilla Firefox browser (recommended). These instructions are for the personal certificate. The process for a business certificate should be similar. We do not recommend Google Chrome because we have had trouble installing Comodo certificates with it.

Comodo links:

- Comodo Home Certificate
- Comodo Business Certificate
To install the certificate, see Email Certificate Install(761). If you need to delete a Comodo certificate, see Email Certificate Revoke(758).

1. In the Mozilla Firefox browser, go to the Comodo certificate page:

2. Click Free Email Certificate. The one page application will display.
Application for Secure Email Certificate

Your Details
First Name
Last Name
Email Address
Country

Private Key Options
Key Size (bits): 2048 (High Grade)

Note: Backup your private key! We do not get a copy of your private key at any time so, after completing this application procedure, we strongly advise you create a backup. Your certificate is useless without it. More info

Revocation Password
If you believe the security of your certificate has been compromised, it may be revoked. A revocation password is required to ensure that only you may revoke your certificate:
Revocation Password
Comodo Newsletter

Subscriber Agreement
Please read this Subscriber Agreement before applying for, accepting, or using a digital certificate. If you do not agree to the terms of this Subscriber Agreement, do not apply for, accept, or use the digital certificate

I ACCEPT the terms of this Subscriber Agreement

3. Fill out the application.
IMPORTANT: Remember the Revocation Password you enter. It is used to delete the certificate in case you need to recreate it. For example, if you created your certificate in Google Chrome by accident, then you can revoke the certificate
and create a new certificate using one of the recommended browsers. Once you have filled in the required fields, click Next.

4. If the certificate creation was successful, you will see a message similar to the following:

**Application for Secure Email Certificate**

**Application is successful!**

Details on how to collect your free Secure Email Certificate will be sent to opendentaltest@gmail.com.

Congratulations on choosing Secure Email Certificates to keep your email confidential.

5. If you use a web email application, open your email client in a new tab of the Mozilla Firefox browser, then locate and open the registration email sent from Comodo. If you use a desktop email client, make sure Mozilla Firefox is your default browser before opening the registration email.

IMPORTANT: You must open your email from the same browser that you applied for your certificate.
Your Comodo FREE Personal Email Certificate is now ready for collection!

Dear Derek Graham,

Congratulations - your Comodo FREE Personal Secure Email Certificate is now ready for collection! You are almost able to send secure email!

Simply click on the button below to collect your certificate.

Click & Install Comodo Email Certificate

Note:- If the above button does not work, please navigate to https://secure.comodo.com/products/SecureEmailCertificate_Collec2 Enter your email address and the Collection Password which is: Tq0BNKJSIrQKxA0D

Your Comodo FREE Personal Secure Email Certificate will then be automatically placed into the Certificate store on your computer.

Click "Yes" if you see a "Potential Scripting Violation" window asking "Do you want this Program to add Certificates now?"

6. Click Click & Install Comodo Email Certificate
   Note: If you used Google Chrome, then your browser may crash during this step, in which case the certificate will fail to install.
7. Click **OK**.
8. Open Mozilla Tools.

9. Click **Options**.
10. Click on **Advanced** (at the top), then the **Certificates** tab.
11. Click View Certificates.
12. Select your email certificate and click **Backup**.
13. Browse to the location where you want to save your email certificate. Use your email address as the file name. Save the file with extension .p12. Click **Save**.
14. Type the password that will lock the certificate file, then click OK.

Your certificate backup is now complete. If someone else get this certificate file from you and they also know the password to unlock it, they will be able to read your encrypted messages.

**Email Certificate Revoke**

See Email Certificate(749).

Revoking a Comodo Email Certificate(749) may be required if you want to recreate your certificate file for your email address because the initial install failed (e.g., you accidentally tried to install the certificate using Google Chrome and the install failed due to Google Chrome crashing).

1. Open your email web client using the browser you used to create the Comodo certificate.
2. Locate the registration email for your Comodo certificate, then click the Revoke Comodo Email Certificate option.
You can revoke your certificate by clicking on the button below.

And as a special thank you,

We are pleased to offer our install and forget solution for securing your e-mails for your use for FREE.

So what are you getting?

3. You will be asked for the Revocation Password you entered when you created the certificate.

If successfully revoked, a message similar to the following will show.

The Secure Email certificate for opendentalehrtest@gmail.com has been revoked

Email Certificate Hosting

In the Email Message Edit (1656) window, at the bottom, click the Certificate button.
To send secure email using Direct Messaging (1666), the public email certificate must be hosted in DNS. Open Dental offers public email certificate hosting or you can host the public certificate elsewhere. To obtain a certificate, see Email Certificate (749).

To host the certificate with Open Dental, you must register the certificate using the registration tool. One certificate can be registered for a particular email address at one time.

Click **Send Code**. You will see the following message once the code is successfully sent.

![Send Code](image)

The email may take a few minutes to show up in your Email Inbox. Open the email to see the verification code. It will look similar to the following:

Subject: Email Certificate Registration From: emailregistration@opendental.com Date: Mon, Jan 05, 2015 3:22 pm To: derek@opendental.com This email has been sent to help you register your email address for use with certificate hosting. Please do not reply to this email. The verification code below will expire in one hour. The verification code below will also expire if another verification code is requested. Your verification code is: IOJHO4

Select and copy the verification code. Open the Email Certificate Registration window and paste the code into the **Verification Code** box.

![Email Certificate Registration](image)

For Step 3, click [...] to browse for and select your public certificate file.

Click **OK**. You will see the following message once the certificate is successfully registered.
Click **OK** to close the message.

Certificates usually expire every 18 months. When your certificate expires, you will need to create a new certificate and register again. When you upload your new certificate, the old one will be overwritten.

**Troubleshooting**

**Receive error:** Email certificate was not registered. Invalid certificate. Cannot find the requested object. Contact Open Dental.

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**Email Certificate Install**

Email security certificates are required for [Encrypted Email](#). Once you have obtained an email security certificate and downloaded the pfx file to your computer, public and private certificate keys must be installed on each computer that will send/receive encrypted email. Also see [Email Certificate](#).

Note: This information is provided as a courtesy to assist you in setting up encrypted email. If you need further assistance, contact an IT professional or refer to your operating system documentation.

On a workstation, there are three folders that pertain to security certificates:

- **NHINDAnchors**: Certificates that you trust. Contains certificates for trusted certificate authorities such as Comodo, and also certificates for specific email addresses which are trusted. If a certificate for a certificate authority is in here, then every certificate created by that authority is also trusted. For example, if you have the Comodo anchor certificate, then you automatically trust any and all certificates created by Comodo.

- **NHINDExternal**: Public certificates for email addresses which you have sent to before or trusted before. These certificates are public information and safe to share with others. These certificates are used to encrypt outgoing messages.

- **NHINDPrivate**: Your private key certificates. These certificates are used to decrypt incoming messages which were encrypted with your public key. Do not share your private certificates with anyone, or else they could use your private key to read your encrypted messages.

If these folders do not already exist, they will be created when you launch and login to Open Dental

**Install Private Keys on a Workstation:**

1. In Windows, click Start. In the Search programs and files field, type `mmc` then press Enter to run the Microsoft Management Console.
2. Click **File, Add/Remove Snap In.**

3. Double click on **Certificates.**

4. Select **Computer Account** and click **Next.**
5. Click **Finish**, then **OK**. Certificate folders will be visible in tree view.

6. Import the .pfx or .p12 file to the NHINDPrivate folder:
   - Right click on the **NHINDPrivate** folder, then click **All Tasks, Import**.
   - Browse for the certificate file on your computer and complete the wizard to install the certificate. Set the file filter to All Files(*.*) to locate the pfx or p12 file.
   - We recommend marking the key as exportable.
   - You will need the key's password. It will be the same password you entered when saving the file. The files will display in the Certificates folder.
7. Export the public key certificate. In the NHIND Private/Certificates folder, right click on the public key (e.g. xxxx@email.com), then click All Tasks, Export. Follow the wizard to export the public key as a .cer file. You may be asked if you'd like to export the private key. If so, choose no.

8. In the NHIND Anchors and NHIND External folders:
   - Right click on the NHIND Anchors or NHIND External folder, then click All Tasks, Import.
   - Follow the wizard to import the public key .cer file saved in step 7.

Note: To send Direct Messages(1666), public keys must also be installed on a hosting server. To host with Open Dental, see Email Certificate Hosting(759).

Trust of Security Certificates: Trust of security certificates is computer-specific. If you send an email from the computer you use as your Email Inbox (Computer Name to Retrieve New Email From in Email Setup(747)), every time you send email, the recipient is added to your trusted list automatically. If you receive a message from unknown recipient that is not in your trusted list, when you open email and decrypt a message, you will be prompted to add the recipient to your trusted list.

Message Element
In the MainMenu(592), click Setup, Manage, Messaging.
Messaging elements are the pieces of information used in Messaging (581) and Messaging Buttons (769).

There are three types of elements:

- **Users**: The User the message is sent to or received from.
- **Extras**: Other text that shows in a message, such as *urgent*.
- **Messages**: The main message text.

Click Add, or double-click on a messaging element to edit.
Select the messaging element criteria, then click OK to save.

- **Type**: Determines the column the element appears in.
- **Text**: The element's identifying label.
- **Sound**: Attach a wave file with an extension of wav (e.g. someone speaking the text).
- **Light Row and Color**: Attached to elements used in messaging buttons.
  - **Light Row**: Use for elements that identify a location (e.g. Op1, Op2, Line 1) or message (e.g. Patient Ready). This is the row that will light up when the element is triggered.
  - **Light Color**: The unique color attached to the element. Usually attached to user or message (e.g. Doctor, Patient Ready).

Once elements are set up, set up the messaging buttons on each workstation (in each operatory). Some may apply to all workstation, others will apply to specific workstations.

Example of a Doctor element: This element has a sound and a color, but no light row. Thus it may determine the color of a light button, but does not cause a button to light up.
Example of an Op 1 element: This element has a sound and a light row, but no color. Thus, this element will light up row 3, but use the color of another messaging element.
Example of a PtReady element: This element has sound, a light row, and a color. Thus, this element will light row 6 purple.

### Sounds
You can attach sound wav files to message element. Then, when a message is sent using the element, a sound notification will accompany the message. Typically the sound is just someone saying the element text. Several sound files are preloaded into Open Dental. There are also 12 additional prerecorded spoken messages (e.g. Hygienist 1, Patient Arrived) available for download: sounds.zip. If you use sounds, make sure your computer volume is turned up.

**Play:** If a sound is already attached to the item, click Play to hear it.

**Delete:** Remove the sound from the element.

**Import:** Import a wav sound file.

**Export:** Export the current wav sound file.

**Windows Recorder:** Record sounds on any Windows operating system except Windows 10 with this button. A sound bar shows that the microphone is picking up sounds.

**Record New:** Record sounds on any operating system, including Windows 10. You can automatically import the sound files with this recorder.

Recording Your Own Sound: You can choose to use Windows Recorder or Record New. These two buttons function the same. Windows Recorder is not compatible with Windows 10.

We recommend a microphone that plugs into your computer. When you are ready to record, follow these steps:

1. Click Record New.
2. Click Record, record your message, then click Stop.
3. Click OK to automatically import the sound file (Record New only).
4. Or, click Save to manually save the file as a wav.
5. Import the sound to attach it to a message element and save it in the database if you click Save instead of OK.

**Messing Buttons**

Messaging buttons appear in a left vertical toolbar below the module buttons.

Messaging Buttons work with Messaging[581] elements to communicate with other computers in the office using light, sound, and/or text. They are a shortcut that is the equivalent of clicking a sequence of messaging elements in the Manage Module[487].

Clicking a button can cause it to light up, cause other buttons to light up, or can trigger no light at all. Click a lit message button to acknowledge.

To customize message buttons, you must complete two steps:
1. Set up Messaging Element[764] (select colors, rows).
2. Set up Messaging Buttons (button text, position, assign messaging elements). See below.

**Example 1:** Notify a doctor they are needed in operatory 1. In this example, clicking one button on one computer causes a different button to light on other computers. This setup is useful when you want to communicate both who is needed and where. You only have to know who you are calling, not the location.
   - On the operatory 1 computer only, set up a button for Doctor with the doctor User element attached.
   - On all computers, have a button for Op 1 (this is the default).
   - In operatory 1, the assistant clicks the Doctor messaging button. This lights up the Op 1 button (row 3) with the doctor’s color on all computers (blue).

**Example 2:** Notify all workstations that a patient is ready.
- On all computers, set up a button for PtReady (this is the default).
- The front desk clicks PtReady. This lights up PtReady (row 6, pink) on all workstations.
More examples are provided at the bottom of this page. Also see Webinar: Messaging and Messaging Buttons.

**Set up Messaging Buttons**

Set up includes selecting the computers a button will show on and the messaging elements that cause a row to light up. Some buttons may apply to all workstation, others will apply to specific workstations.

- Light row of a messaging element determines the button location (row 1, 2, 3, etc.).
- Light color of a messaging element determines the light color.

A few messaging buttons are preset to help you get started.

- Op 1, Op 2, Op 3
- PtReady: Intended to be used by the front desk when a patient is ready to go back to the room.
- PhAsst: Intended to be used when the person answering the phone is on the phone and needs assistance.

In the **Main Menu**(592), click Setup, Manage, Messaging Buttons.

![Messaging Button Setup](image)

All computers in the office list on the left. The computer that you are currently on is indicated by (this computer).

All buttons currently set up for the selected workstation show on the right, listed in row order. If -1-, -2-, etc. shows, the button is blank on this workstation. Up to 40 buttons can be added. Click the up/down arrows to reorder buttons.

Select the computer(s) this button will be set up on (an individual computer or All). Some buttons will be the same for all computers (e.g. Op 1, Op 2, Op 3, Pt Ready, Ph Asst). Others should be specific to each operatory (e.g. Doctor to Op 1 should be set up on the operatory 1 workstation only. Doctor to Op 2 should be set up on the operatory 2 workstation only).

Double-click a button in the Buttons area.
Enter button criteria, then click OK.

- **Applies to all computers vs Only applies to one computer** is set on the previous screen.
- **Text**: The exact label that will appear on the button. Text wraps when it reaches the end of the line.
- **Synch Icon** (optional): Enter a cell number (1-9) that lights up when the corresponding messaging button is clicked. 1-9 refers to one of the cells in Open Dental’s program icon.
  - The cells are numbered 1-9, left to right, starting with the top row and working down.
- **To User, Extras, Message**: Select the messaging elements that will determine the behavior of this button. Light color, sound, and light row is determined by each element.

In the example above, this messaging button will only show on OP1’s workstation. Clicking Doctor will call the user Doctor into Operatory 1. The Op1 button will light up blue on all computers (To Op 1 has a light row of 3 which is the row of the Op1 button; blue is the doctor's light color).

**Examples**
Message button that calls the Assistant to operatory 2: On the Op 2 computer, clicking Assistant will light up the Op2 button pink on all computers (To Op 2 has a light row of 4 which is the row of the Op2 button; pink is the assistant's light color. The sound will be Assistant Op 2.)
Message button for a location (Operatory 1): Clicking this button sends no message. Rather, it shows on all computers and lights up (using the user's color) when a To Op 1 message is sent is from operatory 1.

Message button that lights PtReady on all workstations: On all computers, clicking this button will light up the Pt Ready button and the sound will be *Patient Ready*. 
Hints: To quickly change the default messaging button setup for your office, here are a few guidelines.

- The first and second row are initially blank on all workstations. On each operatory workstation, set up a *this computer* setting that calls a user (e.g. Doctor, Assistant) to that operatory (e.g. To Op 1).
- If you have more than three operatories, create more *location* messaging buttons (e.g. Op 4, 5, 6, etc.). You will need to create new message elements for each (To Op 4, To Op 5) and in each element set the correct light row. Move the PtReady and Ph Asst buttons down a few rows to accommodate the new buttons.
- If you have more than three users that you want to call using a button, create more *user* message buttons (DrA, DrB, Hygienist) that call each user to each operatory (To Op 2, To Op 3). In each user message element, select a unique light color and sound. Move the Op, PtReady, and Ph Asst buttons down to accommodate the new buttons.

**Troubleshooting**

*Message* element properties will override *user* element properties.

Specific buttons can be set up on specific computers. However, if on computer A you set up an Op1 button in row 5, and for all computers you set up an Op 2 button in row 5, computer A will never see the Op 2 button setup for all computers.

For buttons to work correctly, the light row in a messaging element and the button location (row) in Messaging Button Setup must match.

Synch icon doesn't work: This may be due to your operating system. In Windows 7, 8 and 10 you may be able to correct this by right clicking on the taskbar and selecting properties (or taskbar settings). Look for the *Always Combine* option and change it to *Never Combine* or *Combine When Taskbar Is Full*.

**Time Card Setup**

In the [Main Menu](#) (592), click Setup, Manage, Time Cards. The current pay period will be highlighted.
Alternatively this can be accessed in the Manage Module(487), Time Card Setup.

Here you define pay periods, set default time card options, enter ADP company codes, and set up rules for clock in time, overtime, and/or differential hours. Pay periods must exist for the current date in order for employees to use the Time Clock(582).

**Hide pay periods older than 6 months:** Checked by default. Determines which pay periods show in the Pay Periods grid.
- Checked: Hide all pay periods older than six months from today’s date, based on the pay period’s start date.
- Unchecked: Show all pay periods regardless of age.

**Pay Periods:** Pay periods that have been added. Pay periods can be generated automatically or added manually. Click Add One to create a single pay period. Click Generate Many to generate pay periods automatically. Click Delete Selected to remove highlighted pay periods. For steps, see Automatically Generate Pay Periods and Manually Add Pay Periods below. Overlapping pay periods are not allowed.

**Rules:** Time card rules that have been created. Rules can apply to clock in time, overtime, and differential hours. Click Add to create new rules. Click Delete Selected to remove highlighted rules. For steps, see Time Card Rules below.

**Use decimal format rather than colon format:** Determines the time format in the time card. Regardless of the option chosen, total regular and overtime hours are displayed in both colon and decimal format.
- Checked: Display total, daily, and weekly times as a decimal.
- Unchecked: Display the totals in colon format.

Colon format in hours:minutes (e.g. 2:30) equals decimal format of 2.5. To convert back and forth, divide or multiply the last number by 60. 30/60=.5, or .5*60=30. This works for seconds as well as minutes.
Rounding totals: Seconds are not shown in the grid, but are included in the math. A time card that displays minutes rather than decimals may show a total that is greater than if you added together all the times.

**Calc Daily button makes adjustments if breaks over 30 minutes:** Determines how break time that exceeds 30 minutes is handled when Daily totals are calculated. This option is ignored if the Manage Module Preferences (744), *Allow paid 30 minute breaks* is unchecked.
- Checked: When a break exceeds 30 minutes, subtract excess time from the time card using an adjustment. Excess time will be unpaid.
- Unchecked: Include all break time, regardless of length, as paid time.

**Use seconds on time card when using colon format:** Determines whether seconds show on time cards (colon format only).
- Check: Display seconds on time cards (e.g. 12:04:11). Useful when precise calculation of employee hours is necessary.
- Unchecked (default): Only display hours and minutes on time cards (e.g. 12:04).

**ADP Company Code:** If using ADP for payroll, enter your practice's company code as supplied by ADP. This code will show when you click Export ADP in Manage Time Cards (583). To include the employee name when exporting, check the Manage Module Preference, *ADP export includes employee name*.

**Generate Many Pay Periods**
Pay periods can be automatically generated based on a start date and interval.
1. On the Time Card Setup window, click Generate Many.

2. **Start Date:** Select the first pay period that will be generated. The default is today's date unless a pay period already exists for today. In that case, the start date will default to one day after the last pay period's end date.
3. **Interval:** Choose how long the pay periods will last.
   - Weekly: Pay periods will last 7 days.
   - Bi-Weekly: Pay periods will last 14 days.
   - Monthly (default): Pay periods will last one month.
# Pay Periods to Generate indicates the number of pay periods that will be generated. It defaults to the number of pay periods in one year based on the interval. Modify if needed.

4. **Pay Day**: Select the method of determining Paycheck Dates (the day the employees will be paid). There are two options.
   - **Day of Week**: To enable this option, enter 0 for # Days After Pay Period. Click the dropdown to select a day of week. The paycheck date will be the first instance of the day after the end date (e.g., the first Tuesday, Monday, etc. after the end date). In the screenshot above, employees will be paid five days after the pay period end date, as long as it doesn't fall on a weekend. If it does, employees will be paid on the Friday before.
   - **# Days After Pay Period**: Set the paycheck date to a specific number of days after the end date. You can opt to exclude Saturday or Sunday as a paycheck date option. Check the Exclude Weekends box, then select Pay Before or Pay After. Pay Before will set the paycheck date to the Friday before the weekend; Pay After will set the paycheck date to the Monday after the weekend.

5. Click **Generate** to fill the Pay Periods grid.
6. Click OK to save the generated pay periods.

**Manually Add Pay Periods**
Pay periods can be added one at a time.
1. On the Time Card Setup window, click **Add One** under the Pay Periods grid.

2. Enter the start, end, and paycheck dates for the pay period. The dates will automatically populate, but you can edit as needed.
   - If this is the first pay period, today's date is the default. Otherwise the start date defaults to one day after the last pay period's end date.
   - The end date defaults to 14 days from the start date.
   - The paycheck date defaults to 4 days after the end date.
3. Click OK to add the pay period.

**Delete Pay Periods**
Pay periods can be deleted in bulk or one at a time.
- Pay periods that start before today's date cannot be deleted from the Time Card Setup window. Instead, double click the pay period to open the Edit Pay Period window, then delete it.
- The last pay period that has a clock event associated to it cannot be deleted.

Delete One Pay Period: There are two ways to delete a single pay period.
1. In the Time Card Setup window, click a pay period. Click **Delete Selected**. Click OK to confirm.
2. Double click a pay period to open the Edit Pay Period window. Click Delete.

Delete Multiple Pay Periods:
1. In the Time Card Setup window, click and drag to select multiple pay periods.
2. Click Delete Selected.
3. Click OK to confirm.
**Time Card Rules**

Automated time card rules are used for clock in time, overtime, and differential hours in an employee time card. For example, the most common rule calculates overtime for all employees who work more than 8 hours a day. Rules can apply to all or individual employees.

1. On the Time Card Setup window, click Add under the **Rules** grid, or double click a rule to edit.

2. Enter details about the rule.
   - **Overtime if over Hours Per Day**: Enter the number of hours an employee can work per day before overtime is calculated.
   - **Differential Hours**: Enter the time that will be used to determine differential hours. These fields are in 24 hour format.
     - **Before Time of Day**: Hours worked before this time will be marked differential. Enter a time, or click 6AM to insert 6:00 AM.
     - **After Time of Day**: Hours worked after this time will be marked differential. Enter a time, or click 5PM to insert 17:00.
   - **Is Overtime Exempt**: Mark employee as exempt from overtime calculations.
   - **Earliest Clock in Time**: Enter the earliest time an employee is allowed to clock in. Attempts to clock in before this time will trigger an alert indicating when the employee will be allowed to clock in.

3. Select the employees this rule will apply to (all or a specific employee). Each employee can only have one of each rule type that applies to them (one overtime rule and one AM/PM differential rule). If multiple rules of the same type apply to an employee, you will receive errors when calculating.

Note: If using clinics, Headquarters must be selected to set employee specific rules.

To apply a rule, run daily calculations at the end of a pay period. See **Manage Time Cards** (583).
Computers

In the **Main Menu** (592), click Setup, Advanced Setup, Computers.

**Database Server**
- **Server Name**: The name of the Open Dental server.
- **Service Name**: The name of the MySQL service.
- **Service Version**: The version of MySQL that is installed.
- **Service Comment**: Informational comments about the MySQL version.

**Workstation**
- **Current Computer**: FRONTDESK

Computers are added to this list every time you use Open Dental. You can safely delete unused computer names from this list to speed up messaging.

**Fix a Workstation**
Sometimes, OpenDental closes unexpectedly as soon as you choose a database to connect to. The solution is to go to another computer and set the problem computer to use simple graphics. Highlight the computer name at the left that is having the problem and click the button below to reset the graphics.

**Use Simple Graphics**
**Current Computer:** The computer name that is currently running MySQL.

**Computer Name:** Any computer that has used Open Dental. You can safely delete unused computers to speed up messaging. Double-click a computer name to edit the graphics preferences for that computer. This is not recommended.

**Fix a Workstation, Use Simple Graphics:** Set another computer's Graphics Preferences(603) to simple. This is useful as a fix for machines that do not have DirectX or OpenGL installed or working properly. On these machines, sometimes Open Dental closes unexpectedly when a user chooses a database. To fix this, from another computer, click on the computer name, then click Use Simple Graphics. This is the same as selecting the Simple Tooth Chart in Graphics.

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**Generic HL7 Message Structure**

In the **Main Menu**(592), click Setup, Advanced Setup, HL7.

![Image of HL7 Message Structure](image)

**Generic HL7**(784) message structure can be customized to meet the bridging requirements of other software.

There are several internal definitions. Some information can be edited in an internal definition, but messages and segments cannot.

- **eCW Full, Standalone, Tight:** See **eCW HL7 Message Structure**(797).
- **Centricity:** A message definition specifically for Centricity.
- **HL7 version 2.6:** A generic message definition that follows standard HL7 message structure.
- **MedLab HL7 v2.3:** See **LabCorp HL7 Definition**(788) v2.3.

Custom definitions allow editing of all information, including messages and segments. To create a custom definition you have two options:

- Select the internal HL7 version 2.6 definition, then click **Copy**.
- Select an existing custom definition, then click **Duplicate**.

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**Open Dental HL7 Interface Specifications** (PDF)

**Edit a Message Definition**

Double click on the message definition.
**Enabled**: Enable the definition and activate editable fields.

**Mode Tx**: Select a transfer mode (Mode Tx) of File, TCP/IP, or Sftp.

**Delimiters**: Select the separator characters.

**Show Appts Module**: Give access to the Appointments module.

**Show Account Module**: Give access to the Account module.

**Send Quad as Tooth Num**: Usually quadrant information shows as surface information in a claim. However, some insurance carriers require that quadrant information show as tooth number and may reject claims if it doesn’t. Check this box to send quadrant information as tooth number.

**Warn if Procs not attached to Appt**: Show a message prior to sending procedures via HL7 if they are not attached to an appointment.

**HL7 Communication Options**: Set up the inbound and outbound folder paths or ports. The options vary based on the ModeTx. See TCP/IP mode below for steps.
OpenDental HL7 server and service name: See HL7 Service Manager (792) for information about installing and naming the OpenDentalHL7 service.

Show Demographics: Typically patient demographic information is not entered in Open Dental because it may be overwritten every time an inbound HL7 message for the patient is processed. If you want to be able to change and add demographic information in Open Dental, select Change and Add Pts. You will be prompted to enter a password which is hl7.

Messages/Segments: Can only be edited in custom definitions. See Editing Messages/Segments below.

Note: If using TCP/IP mode, we recommend using version 14.1.8 or greater. The incoming and outgoing ports need not match, but the ports will have to be available for use by the OpenDentalHL7 service.

1. For Mode TX, select TcpIp.
2. Enter an Incoming Port.
3. Enter an Outgoing IP: Port (outgoing IP address followed by a colon and a port number). It should match the IP address of the computer Open Dental will send HL7 messages to.

Editing Messages/Segments
For custom definitions, the incoming and outgoing message structure can be modified. To add a new message, click Add. To modify an existing message, double click the message or one of its segments.

Message Type: For a description of all message types, see HL7 Message Types (790).

Event Type: Incoming/Outgoing:

Item Order: Determines the order the message will show in the Message / Segment grid.

Segments: Double click on a segment to modify, or click Add to create a new segment.
**Segment Name**: Can be selected from a list of available segment names supported by Open Dental.

**Item Order**: For outgoing messages, affects the message structure. For incoming messages, only determines the order the segment shows in the Message Edit window.

**Can Repeat**: 

**Is Optional**: 

**Fields**: Double click a field to modify or click Add to create a new field.
**Data Type:** Linked to fields internally defined by Open Dental, so you will only have the option to select a data type for fixed text fields.

**Table ID:** For informational purposes only and is not used by Open Dental or inserted into outgoing messages.

**Item Order:**

**Fixed Text:** Fixed text fields are ignored for incoming messages, and simply inserted in the proper item order for outgoing messages.

**Field Name:** Lists only fields that Open Dental will process for incoming messages or fill in with data from the database when constructing outgoing messages.

**Message History**
To view a log history of HL7 messages, click History on the HL7 Defs window.

Filtering options:

- **Start/End Date:** View log entries for a specific date range. Click Refresh to update the list.
- **Patient**: Click Find to Select a Patient. Click All to include messages for all patients.
- **HL7Status**: View log entries for messages with a specific status. Click Refresh to update the list.

### Generic HL7

HL7 is the name of the file format that Open Dental uses to synch data with other medical software. Generic HL7 is an HL7 interface technology built into Open Dental. These interfaces can be customized to accommodate any software. There are also more options, such as to use TCP/IP instead of shared folders.

For the eClinicalWorks HL7 interface technology, see eClinicalWorks HL7(793) instead.

For LabCorp HL7, see LabCorp HL7(786).

Messages are used to pass information between Open Dental and the other medical software. The Open Dental server will have two shared folders that will be used to pass files back and forth. A service (program without a user interface) called `OpenDentalHL7` will need to be installed on the server. It will handle the interaction between the HL7 messages and Open Dental database.

[Open Dental HL7 Interface Specifications](#) (PDF)

### Updating Open Dental Versions

The OpenDentalHL7 service must be stopped before updating Open Dental on the server, then restarted when the update is complete. In version 15.2 or greater, all OpenDent services are automatically stopped prior to an update, then restarted when complete. Prior to version 15.2, you must manually stop and start services. See Stop Open Dental Services(1415).

### Setup Steps

1. Make sure the client Open Dental program is installed on the server the same as it would be on any other workstation.
2. In the **Main Menu**(592), click Setup, Advanced Setup, HL7. Enable and setup the HL7 message structure. See **Generic HL7 Message Structure**(779).
3. Connect to the Database: The information for connecting to the database is in the `FreeDentalConfig.xml` file in the application folder. This is the same file that the main Open Dental program uses to connect to the database. The information in the file must be accurate before starting the OpenDentalHL7 service. One way to ensure the accuracy is to start the Open Dental client program.
   1. On the **Choose Database**(605) window, set the database connection information. Only simple direct database connections are supported. Uncheck **Do not show this window on startup** so this window will show the next time you launch Open Dental, then close the window. The connection information should auto-save to the xml file. If using Windows 7 or Windows 8, you must right click, **Run as Administrator** when launching Open Dental or the information you enter will not be auto-saved to the `FreeDentalConfig.xml` file.
   2. Verify that the information saved correctly by re-launching Open Dental. If the information is correct, you can be sure that OpenDentalHL7 will connect to the correct database when the service is started.
4. Set up the HL7 Synch Folders (incoming and outgoing). For Generic HL7 this can be entered on the HL7 Def Edit window. For Mountainside(1021), click Setup, Program Links, Mountainside to enter. You will most likely set up the folders from the server, so the paths will be relative to the machine you are on. However, be aware the setup window is viewable from other computers, so from other computers the paths will be invalid.
5. Create a service to send and receive HL7 messages in the Open Dental **Service Manager**(1412). If there are multiple databases for multiple customers hosted on one server, then multiple HL7 services, each with unique names, must be setup. Then, each database must be set up to match with a differently named HL7 service.

### Errors:

If the service does not start as expected:
- Verify that the database and HL7 folders are correct (steps 2 and 3).
- The service will not start if the version is not exactly the same as the version of the main Open Dental program.
- If it still won't start, use the Computer Management tool: My Computer, right click, Manage. Expand System Tools, Event Viewer, Windows Logs. Click on Application. The error and information entries will help determine the reason why the OpenDentalHL7 will not start.
Troubleshooting

Simple Troubleshooting: If the messages are not being passed to OD and processed as expected, follow the steps below.

1. Stop the OpenDentalHL7 service.
2. Edit the FreeDentalConfig.xml file by adding a line for `< HL7verbose > True </ HL7verbose >`.

```xml
<?xml version="1.0" encoding="utf-8"?>
<ConnectionSettings>
  <DatabaseConnection>
    <ComputerName>localhost</ComputerName>
    <Database>opendental</Database>
    <User>root</User>
    <Password></Password>
    <NoShowOnStartup>False</NoShowOnStartup>
  </DatabaseConnection>
  <DatabaseType>MySQL</DatabaseType>
  <HL7verbose>True</HL7verbose>
</ConnectionSettings>
```
3. Start the service.
4. In the other medical software, trigger outbound messages.
5. Wait about 10 seconds for the message to be processed.
6. Look in the Windows Event Viewer Application Log as described in Setup step 5, item 3 above, refreshing as needed.

Verify that the information was processed by Open Dental. Both kinds of messages should result in an insert or update to the patient table. If the message is for a new appointment, the result should also be an insert or update of the appointment table.
7. After troubleshooting, remove the `&lt;HL7verbose&gt;True&lt;/HL7verbose&gt;` line from the xml file. The line will usually be removed automatically when you click OK from the Choose Database window.

Complex Troubleshooting: First perform the Simple Troubleshooting steps above. If that does not solve the problem, follow the steps below.

Note: These steps do not apply if using TCP/IP. Instead use Windows logs or Message History.

1. Turn off OpenDentalHL7.
2. Locate the incoming and outgoing folder paths as set on the HL7 Def Edit window.
3. Open the outgoing folder in Windows.
4. In the other medical software, trigger outbound messages.
5. Look for the message in the outgoing folder. You may need to wait up to 60 seconds for the message to appear.
   - If it does not appear, the HL7 service is not set up properly in the other software to create files.
   - If it does appear, make a copy of the message for later analysis.
   - If the original message does not disappear, then there is a problem with OpenDentalHL7. Look in the Windows Log for errors with the message processing.
   - If the message still does not seem to have been processed, then it will need to be debugged. A copy of the message, and possibly the database itself, should be sent to Open Dental programmers for testing.

Also see HL7 Unit Tests.

LabCorp HL7

HL7(784) is the name of the file format that Open Dental uses to receive data from Laboratory Corporation of America (LabCorp).

Open Dental uses HL7 messages to receive lab results and embedded PDFs from LabCorp. We connect to a SFTP (Secure File Transfer Protocol) site maintained by LabCorp and retrieve the files (HL7 messaging text). A service (program without a user interface) called OpenDentalHL7 needs to be installed on the server. It will handle the interaction between the HL7 messages and Open Dental database.

Updating Open Dental Versions

The OpenDentalHL7 service must be stopped before updating Open Dental on the server, then restarted when the update is complete. In version 15.2 or greater, all OpenDent services are automatically stopped prior to an update, then restarted when complete. Prior to version 15.2, you must manually stop and start services. See Stop Open Dental Services(1415).

Setup Steps

1. Make sure the client Open Dental program is installed on the server the same as it would be on any other workstation.
2. Enable and set up the LabCorp HL7 Definition(788).
3. Connect to the Database: The information for connecting to the database is in the FreeDentalConfig.xml file in the application folder. This is the same file that the main Open Dental program uses to connect to the database. The information in the file must be accurate before starting the OpenDentalHL7 service. One way to ensure the accuracy is to start the Open Dental client program:
   1. On the Choose Database(605) window, set the database connection information. Only simple direct database connections are supported. Uncheck Do not show this window on startup so this window will show the next time you launch Open Dental, then close the window. The connection information should auto-save to the xml file. If using Windows 7 or Windows 8, you must right click, Run as Administrator when launching Open Dental or the information you enter will not be auto-saved to the FreeDentalConfig.xml file.
   2. Verify that the information saved correctly by re-launching Open Dental. If the information is correct, you can be sure that OpenDentalHL7 will connect to the correct database when the service is started.
3. Create a service (OpenDentalHL7 service) to receive HL7 messages in the Open Dental Service Manager(1412). If there are multiple database for multiple customers hosted on one server, then multiple HL7 services, each with unique
names, must be setup. Then, each database must be set up to match with a differently named HL7 service. If already using HL7, you may only need to restart the OpenDentalHL7 service.

Errors: If the service does not start as expected:
- Verify that LabCorps message definition settings are correct.
- The service will not start if the version is not exactly the same as the version of the main Open Dental program.
- If it still won't start, use the Computer Management tool: My Computer, right click, Manage. Expand System Tools, Event Viewer, Windows Logs. Click on Application. The error and information entries will help determine the reason why the OpenDentalHL7 will not start.

### Troubleshooting

Simple Troubleshooting: If the messages are not being passed to OD and processed as expected, follow the steps below.

1. Stop the OpenDentalHL7 service.
2. Edit the FreeDentalConfig.xml file by adding a line for `<HL7verbose>True</HL7verbose>`. Example:
3. Start the service, then monitor the error log.
4. After troubleshooting, remove the &lt;HL7verbose&gt;True&lt;/HL7verbose&gt; line from the xml file. The line will usually be removed automatically when you click OK from the Choose Database window.

LabCorp HL7 Definition
In the HL7(779) window, double-click the row for MedLab HL7 v2.3.
There is one internal LabCorp HL7 (786) definition that exactly matches the LabCorp HL7 message structure (MedLab HL7 v2.3). The transfer mode will always be SFTP. Messages and segments can be viewed but not edited.

To enter or edit SFTP and OpenDental HL7 Server settings:

Check Enabled to activate editable fields.

Enter the HL7 Communication Options:
- **Sftp Server Address Port**: The server address, colon, port. Example: b2bgateway-staging.labcorp.com:20022
- **Sftp Server Results Directory**: Where on the server root directory the lab results can be found for import (typically results).
- **Sftp Username**:
- **Sftp Password**:
- **Lab Result Image Category**: Click the dropdown to select the folder in the Images module where imported lab results and embedded PDFs will be saved.

Enter the HL7 server name and service name.

See [HL7 Service Manager](#) (792) for information about installing and naming the OpenDentalHL7 service.
HL7 Message Types
Below is a description of HL7 inbound and outbound message types that are supported. Outbound message type descriptions also include what actions in Open Dental cause an outbound message.

Generic HL7 Message Structure(779), eCW HL7 Message Structure(797), LabCorp HL7 Definition(788)

Inbound Messages
ACK – General Acknowledgment Message: In TCP/IP mode, every message sent by Open Dental should be acknowledged by the receiving software. If an acknowledgment is not received within 5 seconds of sending a message, an event log warning will be entered and the message will be resent within 6 seconds.

ADT – Patient Demographics Message: Updates patient demographic information. If an inbound ADT message is defined, changes made to patient information within Open Dental may be overwritten by the next inbound ADT message for the patient.

PPR – Patient Problem Message: Either adds a new problem or updates an existing problem, based on the problem action field, usually PPR-1. The problem code in PPR-3.0 must be a SNOMED code identified by SNM (not case sensitive) in PPR-3.2. There must be a problem in the Open Dental database with the same SNOMED code assigned, and there must be a unique identifier with assigning authority root in PPR-4.0 and PPR-4.2 respectively. Start and stop dates are allowed in PPR-7 and PPR-9 respectively, but either or both can be omitted and the problem will still be inserted. If the patient has an active problem with this SNOMED code in their medical chart, but the unique identifier received does not refer to the existing problem, the existing problem will be marked inactive and the new problem will be inserted and linked to the unique identifier. If the patient has an active problem with this SNOMED code and the unique identifier does reference the existing problem, the start and stop dates will be updated and the problem status will be set to active.

SIU – Schedule Information Unsolicited Message: Used when Open Dental assumes the role of an auxiliary application. In this role, Open Dental does not modify the schedule. Appointments are inserted from these inbound messages without regard to operatories or schedules or overlaps. For this reason, when Open Dental is the auxiliary application the Appointment module is hidden. If it was not hidden, there would be errors when the operatories were drawn and all of the appointments for the day were overlapping in the same operatory.

SRM – Schedule Request Message: Used when Open Dental assumes the role of the filler application. In this role, Open Dental maintains and controls the schedules of the providers and operatories. So appointments are created and modified in Open Dental and a definition for an inbound SIU message should NOT be in the enabled HL7 definition. There may, however, be an outbound SIU message defined for communicating appointment information to another software (see Outbound Messages – SIU). Another software may, however, request modifications to existing appointments in Open Dental. These requests are received in the form of an SRM message with event type S03. Only some of the appointment details can be modified by an inbound SRM. The appointment cannot be moved or have the length adjusted, since the external software has no knowledge of the operatory/provider schedules and openings. An inbound SRM message can change the provider (both dentist and hygienist), the confirmation status, the clinic, and the note for the specified appointment. There is also support for breaking an appointment, using an SRM with event type S04 (see the Open Dental HL7 Interface Specifications for an explanation of the different event types).

Outbound Messages
ACK – General Acknowledgment Message If the enabled HL7 definition is set to TCP/IP mode, every message received will be acknowledged by an outbound ACK message. If the message was successfully parsed and processed, the message will contain AA (Application Accept) in MSA-1. If there was an error with the message structure or if a required element was not included in the message, the MSA-1 field will contain AE (Application Error).

ADT - Patient Demographics Message Outbound ADT messages communicate new patient information or updates to existing patient information. ADT messages will be created if there is a definition for an outbound ADT in the enabled HL7 definition in the following situations.
• When patient demographic information is entered into the patient edit window and the OK button is pressed, an ADT message with event type A08 (Update Patient Information) will be created and sent with the updated patient information. If the patient is new, the ADT message will have event type A04 (Register Patient).
If adding new patients from the add family window, one ADT message with event type A04 will be created and sent for each family member.

If a new patient is created from importing a web form, an ADT message with event type A04 will be created and sent.

**DFT – Detailed Financial Transaction Message** Outbound DFT messages communicate information about procedures completed in Open Dental. They can also be used to transmit treatment plan PDFs. DFTs are created and sent if there is a definition for an outbound DFT in the enabled HL7 definition in the following situations.

- For eCW interfaces, if the Finish & Send button is pressed from the Edit Appointment window, an outbound DFT message will be created and sent with the procedure details for the attached procedures as well as a PDF segment containing a PDF version of the procedure information.
- For eCW interfaces, if the Notes PDF button is pressed from the Edit Appointment window, a progress notes PDF will be sent in a DFT message. The DFT message will not contain any FT1 (Financial Transaction Information) segments with procedure information, since the procedures are sent when the "Finish & Send" button is pressed and sending them again could cause duplicates in eCW.
- For eCW interfaces, if the Save TP button in the Treatment module is pressed, a DFT with no FT1 segments will be created and sent with a PDF version of the treatment plan in it.
- For non-eCW users, a button in the Chart module toolbar will appear when an HL7 definition is enabled that will be labeled with the description of the definition on it. Users can select procedures in the progress notes grid and press the button to generate an outbound DFT message with the procedures in it. Pressing the button without first selecting procedures will cause a DFT to be created and sent with any procedures completed with today.

**SIU – Schedule Information Unsolicited Message** SIU messages are sent to communicate appointment related changes to an external application. Five event types are used by Open Dental in outbound SIU messages: S12 – New Appointment, S13 – Appointment Rescheduling, S14 – Appointment Modification, S15 – Appointment Cancellation, and S17 – Appointment Deletion. The following is a list of actions in Open Dental that will trigger an SIU message with the specified event type.

- From the Edit Appointment window, if the status of the appointment is set to Broken, an SIU message with event type S15 will be created and sent when the OK button is pressed.
- From the Edit Appointment window, if an appointment is deleted, an SIU message with event type S17 will be created and sent when the OK button is pressed.
- From the Edit Appointment window, when the OK button is pressed, and SIU message will be sent with event type S12 if it is a new appointment or S14 if it is a modification of an existing appointment.
- From the Appointments for patient window, if the Schedule Recall button is pressed, an SIU message with event type S12 will be created and sent.
- From the Appointment module, if a Planned appointment or an appointment with Unscheduled status is moved from the Pinboard and placed in an operatory on the schedule, an SIU message with event type S12 will be created and sent. If the appointment is moved from the Pinboard to the schedule that is not a new appointment, this is an appointment rescheduling and the event type will be S13.
- From the Appointment module, if an appointment is moved from one time slot to another without the use of the Pinboard, this is an appointment rescheduling and the SIU message created and sent will have an event type of S13.
- From the Appointment module, if either Send to Unscheduled List or Break Appointment are chosen from the right-click menu, or the Break Appointment or Send to Unscheduled List buttons are pressed, an SIU message with event type S15 will be created and sent.
- From the Appointment module, if Set Complete is chosen from the right-click menu or the Set Complete button is pressed, an SIU message with event type S14 will be created and sent.
- From the Appointment module, if Delete is chosen from the right-click menu or the Delete button is pressed, an SIU message with event type S17 will be created and sent.
- From the Chart module, if Set Complete is chosen from the right-click menu, an SIU message with event type S12 will be created and sent.

**SRR – Schedule Request Response Message** An SRR – Schedule Request Response Message is generated and sent in response to an SRM – Schedule Request Message. The SRR notifies the application responsible for sending the SRM whether the requested modification took place or not. Since the only appointment modification supported are updating the appointment note, setting the dentist or hygienist, updating the confirmation status, changing the ClinicNum of the appointment, or setting the appointment status to Broken, the response to an SRM message is usually to confirm that the requested modification took place. The only situations that a requested modification would not be performed is if the patient referenced by the SRM could not be found, the appointment referenced could not be found, an appointment and a
patient were located but the patient located is not the patient on the appointment, or some other error occurred during the processing of the message. In these situations, the SRM will still trigger an SRR, but the SRR will have the acknowledgment code AE (Application Error) in the MSA-1 field.

As long as the patient is found, the appointment exists, the patient on the appointment and the patient referenced by the PID segment are the same patient, and the message is able to be processed correctly (not malformed), the SRM will be acknowledged with acknowledgment code AA (Application Accept) in the MSA-1 field.

**HL7 Service Manager**

The HL7(784) Service Manager is a tool included in the Open Dental application folder used to manage installation of all OpenDentalHL7 services. To begin installation, find the Open Dental application folder. Depending on how Open Dental was installed, this may be C:\Program Files (x86)\Open Dental or simply C:\Open Dental. Double click on ServiceManager.exe.

A list will be populated by all installed OpenDentalHL7 services. As of version 12.4, multiple OpenDentalHL7 services can run on the same server to allow one server to host multiple customer databases. In order for each service to process messages for the correct database, a copy of the Open Dental application folder will have to be made and uniquely named. In the example above, three such folders were created in the following locations.

C:\OpenDentalHL7_DatabaseA
C:\OpenDentalHL7_DatabaseB
C:\OpenDentalHL7_DatabaseC
Each of these folders have the exact contents of the Open Dental application folder with a unique FreeDentalConfig.xml file. The FreeDentalConfig.xml file is how each service will determine which database it is processing messages for. See the HL7 page for information about how a connection to the database is established using this configuration file.

To install a new OpenDentalHL7 service, simply hit the Add button. To modify an existing installed service, double click on one.

![Manage Service](image)

Each service must have a unique service name, and the name must begin with OpenDent. In this example, OpenDentalHL7 was paired with the name of the corresponding database. Once a service name is chosen and the path to the correct OpenDentalHL7.exe is entered, hit the Install button. If the install is successful the status will change from Not installed to Installed, Stopped. Hit the Start button and once started the status will change to Installed, Running.

If the service does not start as expected, see Errors on the HL7(784) page to troubleshoot.

**eClinicalWorks HL7**

HL7 is the name of the file format Open Dental uses to synch data with eClinicalWorks(985) (eCW). HL7 Messages(779) pass information between Open Dental and eCW.

- There are three pre-set eCW HL7 Message Structure(797) definitions that exactly match the HL7 message structure for each of the three bridge modes: Full, Standalone, and Tight.
- The Open Dental server will have two shared HL7 folders that will be used to pass files back and forth.
- A service (program without a user interface) called OpenDentalHL7 needs to be installed on the server. It will handle the interaction between the HL7 messages and Open Dental database.

For generic HL7 setup, see Generic HL7(784) instead.

**Updating Open Dental Versions**

The OpenDentalHL7 service must be stopped before updating Open Dental on the server, then restarted when the update is complete. In version 15.2 or greater, all OpenDent services are automatically stopped prior to an update, then restarted when complete. Prior to version 15.2, you must manually stop and start services. See Stop Open Dental Services(1415).

**Setup Steps**

The setup steps below are usually completed by Open Dental support technicians.

1. Make sure the client Open Dental program is installed on the server the same as it would be on any other workstation.  
2. Setup eClinicalWorks (Setup, Program Links, eClinicalWorks).
   1. Enable eCW.  
   2. Select the bridging mode.  
   3. Set up the HL7 Synch Folders (incoming and outgoing). You will most likely set up the folders from the server, so the paths will be relative to the machine you are on. However, be aware the setup window is viewable from other computers, so from other computers the paths will be invalid.  
   4. Connect to the Database: The information for connecting to the database is in the FreeDentalConfig.xml file in the application folder. This is the same file that the main Open Dental program uses to connect to the database. The
information in the file must be accurate before starting the OpenDentalHL7 service. One way to ensure the accuracy is to start the Open Dental client program:
1. On the Choose Database(605) window, set the database connection information. Only simple direct database connections are supported. Uncheck Do not show this window on startup this window will show the next time you launch Open Dental, then close the window. The connection information should auto-save to the xml file. If using Windows 7 or Windows 8, you must right click, Run as Administrator when launching Open Dental or the information you enter will not be auto-saved to the FreeDentalConfig.xml file.
2. Verify that the information saved correctly by re-launching Open Dental. If the information is correct, you can be sure that OpenDentalHL7 will connect to the correct database when the service is started.
3. Create a service to send and receive HL7 messages in the Open Dental Service Manager(1412). If there are multiple databases for multiple customers hosted on one server, then multiple HL7 services, each with a unique name, must be setup. Then, each database must be set up to match with a differently named HL7 service.

Errors: If the service does not start as expected:
- Verify that the database and HL7 folders are correct (steps 2 and 3).
- The service will not start if the version is not exactly the same as the version of the main Open Dental program.
- If it still won't start, use the Computer Management tool: My Computer, right click, Manage. Expand System Tools, Event Viewer, Windows Logs. Click on Application. The error and information entries will help determine the reason why the OpenDentalHL7 will not start.

### Troubleshooting

**Simple Troubleshooting:** If the messages are not being passed to Open Dental and processed as expected, follow the steps below.

1. Stop the OpenDentalHL7 service.
2. Edit the FreeDentalConfig.xml file by adding a line for `<HL7verbose>True</HL7verbose>`. Example:
3. Start the service.
4. Trigger eCW to create an outgoing message in one of two ways:
   - Edit patient information.
   - Create a new appointment.
5. Wait about 10 seconds for the message to be processed.
6. Look in the Windows Log as described above, refreshing as needed. Verify that the information was processed by Open Dental. Both kinds of messages should result in an insert or update to the patient table. If the trigger message was for a new appointment, the message should also result in an insert or update of the appointment table.
7. After troubleshooting, remove the `<HL7verbose>True</HL7verbose>` line from the xml file. The line may be removed automatically when you click OK on the Choose Database window.

Complex Troubleshooting: Perform Simple Troubleshooting steps first. If that does not solve the problem, follow the steps below.

Note: These steps do not apply if using TCP/IP. Instead use Windows logs or Message History.

1. Turn off OpenDentalHL7.
2. Locate the incoming and outgoing HL7 folder paths as set on the eClinicalWorks Setup window (or HL7 Def Edit window).
3. In Windows, open the outgoing folder.
4. Trigger eCW to create an outgoing message in one of two ways:
   - Edit patient information.
   - Create a new appointment.
5. Look for the message in the outgoing folder. You may need to wait up to 60 seconds for the message to appear.
   - If it does not appear, then the HL7 service is not set up properly in eCW to create files.
   - If it does appear, make a copy of the message for later analysis.
   - If the original message does not disappear, there is a problem with OpenDentalHL7. Look in the Windows Log for errors with the message processing.
   - If the message still does not seem to have been processed, it will need to be debugged. A copy of the message, and possibly the database itself, should be sent to Open Dental programmers for testing.

AptNum doesn't exist in PV1 segment when saving a proposed treatment plan: Open Dental sends an AptNum in the PV1 segment of the outbound DFT messages. This AptNum corresponds to the appointment number eCW sends us in the command line parameters. However, the appointment has to also exist in Open Dental or we won't send it back in the DFT message.

If you are saving a proposed treatment plan, that AptNum may not exist in the PV1 segment due to two situations.
1. You launched OD in a manner other than View Dental Chart from an existing appointment in eCW OR
2. The appointment in eCW doesn't exist in OD. This is probably due to an interface down situation that needs to be resolved.
In either case, the DFT message with the saved treatment plan will be rejected by eCW, sent to an error spool or something, and the PDF will not be added to the patient's chart in eCW.

HL7 Field Documentation
As of version 11.0.31.

**MSH - Message Header**

Every incoming and outgoing message must have a MSH segment, which is usually the first segment. MSH.8 is required to be the message type field and is composed of two components. Component 1 is the message type (ADT, SIU, DFT, etc.) and component 2 is the event type with the designated component separator between them. A typical MSH.8 field would look like this: SIU^S12 or ADT^A04.

**ADT - Demographics Message**

PID.2 (eCW internal patient number) is used to determine patient. If using tight integration, this is stored in the PatNum field in OD. If using standalone integration, this is stored in the ChartNumber field in OD. If a match is not found, then a new patient is created in OD.

PID imports LName, FName, MiddleL, Birthdate, Gender, Race, Address, City, State, Zip, HmPhone, WkPhone, Position(marital), and SSN. If this is a new patient, PriProv is set to practice default.

PID.4 (eCW account number) is saved to the ChartNumber field when using tight integration, but not saved at all when using standalone integration.

PID.22 is parsed for the fee schedule, creating a new one if needed.

GT1 is processed to create a guarantor if needed. The processing is nearly identical as for the PID segment.

**SIU - Scheduling Message**

PID.2 (eCW internal patient number) is used as PatNum to determine patient. If match is not found, a new patient is created with that PatNum.

PID is processed to extract 16 various patient demographic fields.

PID.4 (eCW account number) is saved to the ChartNumber field when in tight integration mode.

PV1 If PV1 segment is missing, AIG is processed instead.

SCH.2 (eCW visit number) is used as AptNum to find or create an appointment. If a found appointment does not match PatNum, error message is shown.

SCH.7 stored in appointment. Note

SCH.11.3 is stored in appointment. AptDateTime

SCH.11.4 (stop time) is used to calculate appointment. Pattern, the length of the appointment.

If AIG segment is present, it is processed for appointment. ProvNum and patient.ProvNum. A provider is created if needed, based on the eCW alphanumeric provider id.

If AIG segment is missing, PV1 is processed instead.

**DFT - Charge Specification**

PID.2 (eCW account Number)

PID.3 (eCW internal patient number)

PID includes an additional 14 patient demographic fields

PV1 includes provider information

PV1.19 (eCW visit number) The AptNum that was originally passed in by eCW.

FT1 A series of segments for all the procedures.

ZX1.5 If this DFT is being used to send a treatment plan, then this is a pdf file, encoded as base64 string. Otherwise, blank.

Also see [HL7 Unit Tests](#).
eCW HL7 Message Structure

In the Main Menu(592), click Setup, Advanced Setup, HL7.

There are three internal eClinicalWorks HL7(793) message definitions that exactly match the HL7 message structure for the three eCW bridge modes: Full, Standalone, and Tight. These message definitions are automatically enabled when the eCW bridge is turned on for a specific bridge mode. To set up generic HL7 messages, see Generic HL7 Message Structure(779).

Usually you will not modify message definitions here, but if you do (enable and modify), the options set here will override HL7 options defined on the eClinicalWorks Setup window. See eCW HL7 under HL7 Field Documentation and HL7 Unit Tests for more information.

Only Custom definitions can be edited.

- To create a new custom definition, select an internal definition then click Copy.
- To copy an existing custom definition, select it then click Duplicate.
- To edit a definition, double click it.
For internal definitions, only information in the top portion of the window can be modified. Messages/Segment structure cannot be changed.

- **Enabled**: Enable the definition and activate editable fields.
- **Description**: The identifying name of the definition.
- **Mode Tx**: Select a transfer mode (Mode Tx) of File, TCP/IP, or Sftp.
- **Delimiters**: Select the separator characters.
- **Show Appts Module**: Give access to the Appointments module.
- **Show Account Module**: Give access to the Account module.
- **Send Quad as Tooth Num**: Usually quadrant information shows as surface information in a claim. However, some insurance carriers require that quadrant information show as tooth number and may reject claims if it doesn't. Check this box to send quadrant information as tooth number.
- **Send Long D Codes**: When checked, CDT codes that are longer than five characters will be allowed in outbound DFT messages. This will affect duplicate procedure checks.
- **Warn if Procs not attached to Appt**: Show a message prior to sending procedures via HL7 if they are not attached to an appointment.
- **HL7 Communication Options**: Set up the inbound and outbound folder paths or ports. The options vary based on the ModeTx. See TCP/IP mode below for steps.
• **OpenDental HL7 server and service name:** See HL7 Service Manager(792) for information about installing and naming the OpenDentalHL7 service.

• **Show Demographics:** Typically patient demographic information is not entered in Open Dental because it may be overwritten every time an inbound HL7 message for the patient is processed. If you want to be able to change and add demographic information in Open Dental, select Change and Add Pts. You will be prompted to enter a password which is hl7.

• **Messages/Segments:** Can only be edited in custom definitions. See Editing Messages/Segments below.

**Hint:** If using TCP/IP mode, we recommend using version 14.1.8 or greater. The incoming and outgoing ports need not match, but the ports will have to be available for use by the OpenDentalHL7 service.

1. For Mode TX, select **TcpIp**.
2. Enter an Incoming Port.
3. Enter an Outgoing IP: Port (outgoing IP address followed by a colon and a port number). It should match the IP address of the computer Open Dental will send HL7 messages to.

**Editing Messages/Segments**

For custom definitions, you can modify the incoming and outgoing message structure (shown in the Messages / Segments grid). To add a new message, click Add. To modify an existing message, double click the message or one of its segments.

**Message Type:** For a description of all message types, see HL7 Inbound and Outbound Message Types(790)

**Event Type:**
Incoming/Outgoing:

**Item Order**: Determines the order the message will show in the Message / Segment grid.

**Segments**: Double click on a segment to modify, or click Add to create a new segment.

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**Segment Name**: Can be selected from a list of available segment names supported by Open Dental.

**Item Order**: For outgoing messages, affects the message structure. For incoming messages, only determines the order the segment shows in the Message Edit window.

**Fields**: Double click a field to modify, or click Add to create a new field.
**Data Type:** Linked to fields internally defined by Open Dental, so you will only have the option to select a data type for fixed text fields.

**Table ID:** For informational purposes only and is not used by Open Dental or inserted into outgoing messages.

**Item Order:**

**Fixed Text:** Fixed text fields are ignored for incoming messages, and simply inserted in the proper item order for outgoing messages.

**Field Names:** Lists only fields that Open Dental will process for incoming messages, or fill in with data from the database when constructing outgoing messages.

**Message History**
To view a log history of HL7 messages, click History on the HL7 Defs window.
Filtering options:

- **Start/End Date**: View log entries for a specific date range. Click Refresh to update the list.
- **Patient**: Click Find to Select a Patient. Click All to include messages for all patients.
- **HL7Status**: View log entries for messages with a specific status. Click Refresh to update the list.

**FHIR**

In the **Main Menu** (592), click Setup, Advanced Setup, FHIR.

Open Dental's FHIR service is a RESTful API service that allows third-party developers to query an Open Dental
database for certain types of information. The service can be used to read and create patients, appointments, procedures, and more.

Click Add Key or double click an entry to edit:

For details about use and setup, see:
- Version 19.3: [Open Dental FHIR Interface Specifications for 19.3](https://www.hl7.org/fhir) (PDF)
- Version 19.2: [Open Dental FHIR Interface Specifications for 19.2](https://www.hl7.org/fhir) (PDF)
- Version 19.1: [Open Dental FHIR Interface Specifications for 19.1](https://www.hl7.org/fhir) (PDF)
- Version 18.4: [Open Dental FHIR Interface Specifications for 18.4](https://www.hl7.org/fhir) (PDF)
- Version 17.4: [Open Dental FHIR Interface Specifications for 17.4](https://www.hl7.org/fhir) (PDF)
- Version 17.1: [Open Dental FHIR Interface Specifications for 17.1](https://www.hl7.org/fhir) (PDF)
- Version 16.3: [Open Dental FHIR Interface Specifications for 16.3](https://www.hl7.org/fhir) (PDF)

We currently offer a test server that developers can use to experiment with FHIR.

Current resources that can be queried:
- appointment status, operatory, and clinic
- patient demographics
- organization (practice)
- practitioner (provider specialty)
- provider and operatory schedule
- available time slots
- subscriptions (receive notifications about changes made to patients and appointments)
- conditions (problems)
- allergy intolerance (allergies)
- medications
- medication statements (a medication for one patient)
- procedures

Open Dental FHIR conforms to the FHIR standard defined at [https://www.hl7.org/fhir](https://www.hl7.org/fhir).

**Replication Setup**

In the [Main Menu](592) click Setup, Advanced Setup, Replication.
These steps should be followed when first setting up One-Way Replication or Daisy Chain Replication. In general you will do the following:
1. Add each server.
2. Designate a slave monitor for each server.

A slave monitor computer constantly monitors the health of the replication process. One computer must be designated as the slave monitor, and each server must have the slave monitor specified in the Slave Monitor field.
- The slave monitor should stay on and logged on to Open Dental at all times.
- The slave monitor does not need to be the replication server; it can be the name of any workstation on the network. Typically, users specify the replication server as its own monitor because Open Dental must be running and a user must be logged on for the monitor to work. It should at least be a computer that is on the same network as the replication server so it will continue to function normally if the internet goes down.

Example: There are two replication servers (A and B) at two different offices. In server A’s office, the replication monitor could be any computer on network A. It would not be a computer on network B, because if the internet went down, the monitor would quit working.

Note: If you previously set up replication and turned random primary keys on, see Random Primary Keys instead. Using random primary keys is no longer recommended; instead we recommend using offset keys.

Click Add to add a server, or double-click a server to edit.
Enter the server information:

**Server Description**: The description of the server. This description can be changed but it should match your server name or IP address exactly. We recommend using the IP address to reduce possible DNS issues. Not actually linked to the Clinic table.

**server_id**: Assign a unique server_id to each server. This ID will be specified in the my.ini file during setup. Each workstation can then use a query to identify which server it is connected to.

**A to Z folders**: Assign each server an A to Z folder. It can differ by server. This allows use of a folder in the local area network rather than one that’s accessed across a VPN. This path will show in the Data Path window (Paths(824)). Keeping the A to Z folders synchronized between locations is up to the customer and requires additional software and expertise (see Folder Replication).

**Update Blocked**: Set whether an Open Dental software update can occur from this server. We recommend updating Open Dental from only one server and blocking updates from others.
- **Checked**: No workstation connected to this server will be allowed to initiate an update. This is typically checked for servers that are considered slave or peripheral. It is possible that this could prevent startup of the program in certain situations.
- **Unchecked**: Workstations connected to this server can initiate an update.

**Report Server**: Flag the server as a report replication server so it can run dangerous Queries such as those with CREATE TABLE or DROP TABLE syntax. These queries can cause replication failure so should only be run on report servers. More than one computer can be a 'report' server.

**Slave Monitor**: Specify the computer that will monitor the status of the replication process. If replication fails, this computer will be responsible for disabling access to Open Dental from all computers on this server until replication has been restored. The slave monitor should stay on and logged on to Open Dental at all times.

**Note**: Only click This Computer if entering the Slave Monitor. This button will populate the local computer’s name and can override information if used incorrectly.
Sync Databases
Syncing databases will update all databases in the chain with new entries.
1. Enter the MySQL username and password. MySQL Security
2. Click Synch.

Note: Open Dental will use the text in the server Description as the computer name for each replication server. The synch will fail if the description is not a valid replication server computer name.

Slave Monitor Triggers and Technical Details
To detect replication failure, Open Dental must be running on the designated slave monitor computer.

How replication failure is detected.
- The monitor polls the slave status every 10 seconds with the following query: SHOW SLAVE STATUS \G;
- If the Slave_SQL_Running and Slave_IO_Running column does not equal "Yes", then the slave updates the database to trigger that replication has failed. For example if server ID is 3:
  UPDATE preference SET ValueString = '3' WHERE PrefName = 'ReplicationFailureAtServer_id';
- If the Slave_SQL_Running and Slave_IO_Running column show "Yes" and the Last_Errno column is blank, then the user will receive "Warning: Replication data receive is off at server [Server]. The server will not receive updates until the slave is started again. Contact your IT admin to run the SQL command START SLAVE.". This usually happens when the slave is manually stopped with an SQL statement.
- All users are kicked out of Open Dental on all servers.
- When users try to use Open Dental on the failed slave, they are told, "This database is temporarily unavailable. Please connect instead to your alternate database at the other location".

It is up to the administrators of the replication service to ensure that training is in place to make sure users know what to do when they see this message.

The slave monitor will detect failure if replication stops or fails on any server, for any reason. So do not stop replication unless Open Dental is shut down on the monitor. The slave monitor will not react to loss of internet connection; MySQL will gracefully continue replication where it left off when reconnected. Stopping the MySQL service will cause other error messages in Open Dental, but will not trigger a reaction by the slave monitor.

Replication Troubleshooting

Show Features
In the Main Menu(592), click Setup, Advanced Setup, Show Features.
Use Show Features to turn on/off features of Open Dental that your office uses. Settings will affect all computers using the same database. Often you will need to restart Open Dental for the settings to take effect.

Check a feature to turn it on. Uncheck a feature to turn it off.

Click OK to save settings.

Restart Open Dental if needed.

**Capitation:** Show [Capitation Insurance Plans](120) as an insurance type option on the [Insurance Plan](81).

**Medicaid:** Show the following fields:
- Medicaid ID and State fields on the [Edit Patient Information](62). You can also set up validation for these fields in [Required Fields](71).
- BillingType1 and BillingType2 fields on the [Procedure](303). BillingType fields can then be manually set per procedure in order to flag procedures for inclusion in custom reports.

**Public Health:** Turn on [Public Health](71) features.

**Dental Schools:** Turn on [Dental Schools](808).

**Hospitals:** Show *Print Day for Hospital* option when you right click on the Progress Notes in the Chart module. This option will print only completed procedures, a photo of the patient (if available), and a signature line at the bottom for the staff to sign. This printout is intended to go in the physical chart.
**All Insurance**: Show insurance information in the Family module and insurance estimates in the Treatment Plan module.

**Clinical (computers in operatories)**: When unchecked, the Chart module toolbar button changes to Procs, procedures can only be treatment planned or completed for billing, and the Diagnosis/Prognosis panels are hidden. To also remove the Patient Info panel, edit the Chart Layout(460) sheet.

**Basic Modules Only**: Only show the Appointments, Family, Account, and Chart modules.

**Clinics**: Turn on Clinics(1505) (e.g. when you have multiple locations). If you turn clinics off while using eServices, you will get the following prompt. Click OK to save and review the eService Signup Portal.

![Image of eServices prompt]

**Repeating Charges**: Turn on Repeating Charges(1465).

**Medical Insurance**: Turn on Medical Insurance(128) features.

**EHR**: Turn on EHR features (EHR Modified Stage 2). If using EHR for the EHR Incentive Program, contact Open Dental to sign an EHR Contract.

**Super Families**: Turn on Super Family(143) feature.

**Patient Clone**: Turn on Patient Clones(145). Useful for orthodontist offices who want to track production and income separately.

**Questionnaire**: Enable the Questionnaire(1195) feature. A Questionnaire button will show in the Account module toolbar.

**Show Reactivations**: Enable the Reactivation List(33). A Reactivation tab will show in the Recall List and a setup window will be available under Setup, Appointments.

**ERA window shows ControlID filter**: Allows ERA(568) window to be filtered by Control ID.

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**Dental Schools**

Open Dental works well in large dental schools or dental hygiene schools.
To turn on dental school features, in the **Main Menu** (592), click Setup, Advanced Setup, **Show Features** (806). Check the box for Dental Schools.

**Setup Steps:**
1. Set up **Dental School Classes** (1232)
2. Set up **Dental School Courses** (1233)
3. In Security:
   1. Create **User Groups** (1115) for students and instructors.
   2. Set **Dental School Setup** (896).
   3. Set user names and passwords.
4. Add **Dental School Students** (1263), **Dental School Instructors** (1261) and other **Dental School Providers** (1260).
5. Add, copy, and manage course **Dental School Requirements Needed** (1478).
6. Set up **Dental School Grading Scales** (899) and **Dental Student Evaluations** (1439).

**Use:**
- **Fill out Student Evaluations** (1440)
- **Generate Dental Student Reports** (1442) as needed

**Also See:**
- **Dental School Servers** (809)
- **Dental School Evaluation Setup** (897)
- **Dental School Enhancements** (809)

**Note:** The option **Only show operatories for scheduled providers** in **Appointment Views** (7) may be useful for dental schools. It allows you to dynamically change the day’s view based on scheduled providers.

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**Dental School Enhancements**

Open Dental works well in **Dental Schools** (808), but there are a number of enhancements that would make it even more attractive.

**Dispensary:** Select a student, then scan items to check out to that student. Check in any items as they arrive without selecting student first. This functionality can be easily handled by a third-party software temporarily until it becomes available in Open Dental.

**Dental Lab Cases:** **Dental Lab Cases** (379) could use better support for cases that go back and forth to the lab, redos, multiple visits, etc.

**Reports:** There are few reports for schedules, grades, requirements, or instructors. Of course, **User Queries** gives large organizations all the power they could want. Also, external reporting tools can access the database if needed.

**Assign Patients:** Currently, a patient is assigned to a provider by setting the primary provider in the Patient Edit window. AxiUmallows/forces assigning providers for a date range corresponding to their clinical rotation. There is only a slight advantage to doing this. Very little functionality is lost by not having rigorous assignment of patients.

**Web Version:** A few dental schools have insisted that they need web based software. This would reduce the burden of installing software on each machine. It could also potentially allow shifting the hardware offsite to a hosting facility if the school is willing to give up that control and is prepared to pay the associated costs. A web version geared for dental schools is not one of our short-term goals.
Here are some ideas for Dental Schools server organization:

**MySQL Server**: Running the MySQL database.

**Application Server 1**: Running our Middle Tier for security.

**Application Server 2 (optional)**: Also running the Middle Tier. Serving more workstations (&gt;60?). This may not be needed if Application Server 1 is adequate for the number of workstations.

**Remote Desktop Server (optional)**: Using either MS or a competing remoting solution. This would only be for a few remote users, not for the majority of users.

**Report Server (optional)**: Running a Replication slave database to take some load off the MySQL Server. If a malformed query is run, this report server will go down instead of the MySQL Server. You should limit primary keys to a narrow range.

**File Server (maybe optional)**: For storing images, especially radiographs, but also scanned documents. The needed capacity of the file server will vary widely between institutions. If any scanning or digital imaging will be performed, this should be a separate server.

**Scheduled Processes**

In the MainMenu, click Setup, Advanced Setup, Scheduled Processes.
Scheduled Processes allow certain updates to be performed regularly, at a designated time. Typically these should be scheduled for after hours to avoid disruption of normal program function as these tasks can be server intensive.

The main grid displays any currently existing scheduled processes. Double-click to edit.

**Add**: Click to create a new scheduled action.

- **Scheduled Action**: Select Process to run from the dropdown.
  - *Recall Sync*: Recalculate due dates for all patients based on current Recall Types (635).
  - *Ins Batch Verify*: Verify insurance through Electronic Eligibility and Benefits (108). Batch is defined by who is currently...
in the Insurance Verification List(49), based on the criteria set in Insurance Verification Setup(627). Carriers(1237) must have Is trusted for real-time eligibilty checked.

Note: Ins Batch Verify is in extended beta. We do not recommend using this feature until this note is removed.

- **Frequency to Run**: Select how frequently this process will run.
- **Time to Run**: Enter a time of day when this process will run. Entries will be validated based on local language/cultural settings in Windows. For English-US users, acceptable time formats for entry include: 9:00 PM, 9:00 pm, 21:00.
- **Delete**: Click to remove this scheduled process.

### Alert Categories
Alerts can be grouped into categories, which can then be assigned to users.

In the **Main Menu**(592), click Setup, Alert Categories.

A list of internal groupings show at left. Customized alert categories show on the right. Only customized alert categories can be edited.

- All: All Alerts(1635).
- eServices: Alerts about eServices.
- eRx: Alerts about DoseSpot Alerts(348).

### Add an New Category
Highlight an internal alert category, then click Copy. Or highlight a custom alert category and click Duplicate. The new category will list under Custom.

**Edit Alerts in a Category**

1. Double-click a custom category.

2. Highlight the alerts to attach to the category. Deselect the alerts you do not want attached to the category.
3. Click OK to save.

Note: Each custom alert category has a child/parent relationship with the internal category it was copied from. Thus, if a new alert is added to an internal category (the parent), the alert is also automatically added to the custom category (the child).

**Delete an Alert Category**

1. Double-click a custom alert.
2. Click Delete.

**Auto Codes**

In the Main Menu, click Setup, Auto Codes.
Auto codes work behind the scenes to insert and validate the correct procedure code depending on a variety of tooth conditions. Auto codes can be associated with Procedure Buttons(736). Open Dental comes preloaded with many auto codes, but you may want to add more.

Examples:
- When you select a primary tooth, two surfaces, then click the Amalgam procedure button, the auto code will insert the correct procedure code (D2150).
- While Enter Treatment(301), if you select three surfaces for a two surface procedure code, Open Dental will recognize the mismatch and prompt you to change to the recommended three surface procedure code. To set whether or not staff is required to accept auto code suggestions, see Chart Module Preferences(706), Require use of suggested auto codes.

To reset auto codes to the default settings, see Procedure Code Tools(1198).

Webinar: Procedure Buttons, Quick Buttons, and Auto Codes

Add or Edit Auto Codes
Examples of auto codes you may want to add:
- Immediate denture
- Non-ADA codes such as Crown Seat which could automatically select between PFM seat and All Ceramic seat based on Anterior/Posterior.

The auto codes listed above are the defaults.

Click Add, or double-click an auto code to edit.
All procedure codes associated with the auto code will list.

Enter the Description of this auto code.

Add each procedure code that should be associated with this auto code and define the conditions that will trigger it. All possible conditions must be defined for the auto code to work correctly. Composite example (above):

- There is one procedure code for each possible combination of Anterior/Posterior and number of surfaces.
- 2 locations (Anterior/Posterior) multiplied by 5 surfaces equals 10 auto code conditions that must be defined for a Composite.
- Since four-surface and five-surface fillings share the same ADA code, there will be some duplicate codes. The four surface and five surface conditions should not be put on a single auto code item, since that would require that both conditions be true for that code to be selected, which is absolutely impossible.
1. Click Change to select the procedure code from the Procedure Code List (1195).
2. Highlight the conditions that will trigger this procedure code, then click OK to save.
3. Repeat sub steps 1-3 for each procedure code in this auto code.

When selecting conditions, there are some logical groupings. You should never select two conditions from the same group since both conditions can not possibly be met simultaneously.
- Anterior and Posterior are opposites.
- Anterior is also part of the Molar/Premolar group.
- The five surfaces are a group.
- First is the opposite of EachAdditional.
- Maxillary is the opposite of Mandibular.
- Primary is the opposite of Permanent.
- Pontic is the opposite of Retainer.
- The AgeOver18 condition is non-functional and should not be used.

Most of the conditions are simply based on tooth number.
- For instance, for tooth number 5, the Anterior condition is false, the Posterior condition is true, and the Premolar condition is true.
- First and Each Additional really only apply if you have selected multiple teeth on the chart and click a procedure button, perhaps for a PA. The first one meets the First condition, and the remaining will be Each Additional.
- Pontic and Retainer are also unusual. A tooth is considered missing if it has been marked as missing in the Chart module (298) (an extraction or using Missing Teeth (323)). So the Pontic condition is met if the tooth is missing, and the Retainer condition is met if the tooth is not missing.
Other options:
- Hidden: If checked, this auto code will not be available for selection on the Edit Procedure Button (303) window.
- Do not check codes in the procedure edit window, but only use this auto code for procedure buttons: If checked, this auto code will only be used when entering treatment using a Procedure Button. It will not be used for validating procedure codes entered on the Procedure (303) edit window. Thus, the validation message usually triggered when an entered procedure does not match the entered procedure code will no longer popup. To restart the validation message, uncheck this box.

Canada Auto Codes
For Canada users, in the Main Menu (592), click Setup, Auto Codes.

Auto codes work behind the scenes to insert and validate the correct procedure code depending on a variety of tooth conditions. Auto codes can be associated with Procedure Buttons (736).

Also see Canada Procedure Code Tools. For U.S. auto code examples, see Auto Codes (813).

You may need to enter more than the default auto codes. For example, there is no default auto code for amalgams.

In the Edit Auto Code window, click Add, or double-click an auto code to edit.
All procedure codes associated with the auto code will list.

**Description:** Enter the Description of this auto code.

**Hidden:** If checked, this auto code will not be available for selection on the Edit Procedure Button window.

**Do not check codes in the procedure edit window, but only use this auto code for procedure buttons:** If checked, this auto code will only be used when entering treatment using a Procedure Button. It will not be used for validating procedure codes entered on the Procedure(303). Thus, the validation message usually triggered when an entered procedure does not match the entered procedure code will no longer popup. To restart the validation message, uncheck this box.

Add each procedure code that should be associated with this auto code and define the conditions that will trigger it. All possible conditions must be defined for the auto code to work correctly.

1. Click Add or double-click an existing auto code to edit.
2. Click Change to select the procedure code from the Procedure Codes(1195).
3. Highlight the conditions that will trigger this procedure code, then click OK to save.
4. Repeat sub steps 1-3 for each procedure code in this auto code.
When selecting conditions, there are some logical groupings. You should never select two conditions from the same group since both conditions can not possibly be met simultaneously.
  o Anterior and Posterior are opposites.
  o Anterior is also part of the Molar/Premolar group.
  o The five surfaces are a group.
  o First is the opposite of Each Additional.
  o Maxillary is the opposite of Mandibular.
  o Primary is the opposite of Permanent.
  o Pontic is the opposite of Retainer.
  o The AgeOver18 condition is non-functional and should not be used.

Most of the conditions are simply based on tooth number.
  o For instance, for tooth number 14, the Anterior condition is false, the Posterior condition is true, and the Premolar condition is true.
  o First and Each Additional really only apply if you have selected multiple teeth on the chart and click a procedure button, perhaps for a PA. The first one meets the First condition, and the remaining will be Each Additional.
  o Pontic and Retainer are also unusual. A tooth is considered missing if it has been marked as missing in the Chart Module (298) (an extraction or using Missing Teeth (323)). So the Pontic condition is met if the tooth is missing, and the Retainer condition is met if the tooth is not missing.

Click OK to save the auto code.

Automation

Automation can be used to automatically perform actions when a specific trigger occurs and condition is met.

In the Main Menu (592), click Setup, Automation.
Webinar: Automation in Open Dental

Examples:
- Pop up a warning when a patient's insurance plan effective date ends.
- Pop up warning for a patient who has a specific allergy or condition.
- Generate patient instructions when a specific procedure is completed (e.g. extraction).
- Automatically generate a letter when a patient misses their appointment.
- Automatically generate a letter to a referral source when a new patient schedules their first appointment.
- Restrict appointment scheduling when a patient has a specific billing type (e.g. collections).

Note: A logged-on user's Security Permissions (1115) may affect automation. For example, if a user has permission to change a billing type, but not to restrict appointment scheduling, an automation to mark the Appointment Scheduling is Restricted checkbox when a specific billing type is selected will not occur. The PatientApptRestrict security permission is required.

Click Add to create a new automation, or double-click on an existing automation to edit.

Options available may change depending on the selected Trigger and/or Action.
Description: Enter the identifying name of the automation.

Trigger: Select the action that will trigger this automation. There are eight options:
- CompleteProcedure: When a procedure is set complete (Set Appointment Complete).
- BreakAppointment: When an appointment is broken (Break Appointment).
- CreateApptNewPat: When an appointment is created for a patient with no appointment history (new patient).
- OpenPatient: When a patient's record is opened/selected.
- CreateAppt: When an appointment of any type is created.
- ScheduleProcedure: When a specific procedure is scheduled. See below to specify procedure(s).
- SetBillingType: When a billing type changes (Edit Patient Information).
- RxCreate: When a new prescription is created for a controlled substance or when a new prescription is created that requires a procedure code. Works with the conditions IsControlled and IsProcRequired. For electronic prescriptions the automation will occur when the prescription is imported to Open Dental. Also see DoseSpot eRx / Prescription, Writing and Transmitting Legacy eRx Prescriptions, Rx / Prescription.

Procedure Code(s): If CompleteProcedure or ScheduleProcedure is the trigger, enter the procedure codes, separated with commas (no spaces), or click [...] to select from the Procedure Codes.

Conditions (optional): Set conditions that must be met for the trigger to occur.
1. Click Add or double-click on an existing condition.

- Select the condition details then click OK.
  - Field: The field that will be checked.
  - Comparison: The qualifier.
  - Text: The text that must be matched. For Billing Type click [...] to select from a billing type pick list.
- Conditions are ANDed together. In other words, they must all be true for the automation action to be fired. To handle OR conditions, create separate automations.

Action: Select the automated action that will occur when the trigger and/or conditions are met.
- PrintPatientLetter: Generate Letter (e.g. for patient handouts). To generate multiple handouts, create multiple automations.
- CreateCommlog: Open the Commlog window.
- PrintReferralLetter: Generate ReferredFrom Referral Letter.
• ShowExamSheet: Open blank Exam Sheet(397).
• PopUp: Show a popup message.
• SetApptStatusASAP: Set the appointment status to ASAP.
• ShowConsentForm: Open the selected Consent Form(395).
• SetApptType: Set the Appointment Types(619) when CreateApptNewPat or CreateAppt trigger is selected.
• PopUpThenDisable10Minutes: The popup message appears once, then the automation is disabled for 10 minutes.
• PatRestrictApptSchedTrue: Restrict appointment scheduling for the patient by marking the Appointment scheduling is restricted checkbox on the Edit Patient Information window. Typically used when SetBillingType is the trigger.
• PatRestrictApptSchedFalse: Do not restrict appointment scheduling for the patient (unchecks the Appointment scheduling is restricted checkbox on the Edit Patient Information window). Typically used when SetBillingType is the trigger.
• PrintRxInstruction: Generate Rx Instructions(1183) for a patient when instructions are added to a new prescription.
• Change Pat Status: Change the patient status for the selected patient.

Sheet Def: Shows when PrintPatientLetter, PrintReferralLetter, or ShowExamSheet is selected as the Action. Select the sheet template to use. See Sheets(1123).

Comm Type: Shows when CreateCommlog is selected as the Action. Select the default comm log type.

Message: Shows when CreateCommlog or PopUp is selected as the Action. Enter the default message.

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**Auto Note Setup**

In the Main Menu(592), click Setup, Auto Notes.

![Auto Notes](image)

Auto Notes(317) are templates used to insert large complex notes that you enter frequently in various text boxes throughout Open Dental. In addition to static text, prompts can offer a selection of responses or the ability to enter text.

All auto notes currently setup will list, organized in tree view.

- Click + to expand a folder tree.
- Click - to collapse.
- Check or uncheck the Collapse All checkbox to quickly collapse or expand all folders.

To create or reorder folders, see Definitions: Auto Note Categories(848).

To move an auto note to a different folder, select the auto note then drag it to another folder.
Create Auto Notes

On the Auto Notes window, click Add, or double-click on an existing auto note to edit.

The current text in the note is on the left. Prompts within the note are indicated by [Prompt:"""].

**Name**: Enter an identifying name for the auto note.

**Text**: Enter the static text of the auto note.

**Available Prompts**: All prompts currently setup list here. To insert a prompt, position the cursor in the Text field at the point of insertion, highlight the prompt, then click Insert.

**Create or Edit Prompts**

Click **Add** to create a new prompt, or double-click an existing prompt to edit.
Description: Identifying name of the prompt.

Prompt text: The text that will indicate what information is requested. There is a 50 character limit. Prompts longer than 50 characters can be entered in the Text field of the Auto Note Edit window.

Type: There are three types of prompts:
- OneResponse: User can select one option from a list of options.
- MultiResponse: User can select many options from a list of options.
  Note: When listing responses, do not use commas to list items. Instead, make a new response per line for each option. You can select more than one response from the list.
- Text: User can enter free-form text.

Possible responses: For OneResponse or MultiResponse types only. Enter one response option per row.

Default Text: For Text types only. The default text that will show as the response. May leave blank. Users will be able to edit as needed.

Auto Note Response: For OneResponse only. Useful when an auto note can be used for multiple scenarios.

Up/Down: Quickly reorder the list. Click an item then click up or down.

Paths
In the Main Menu(592), click Setup, Data Paths.
Note: If you start seeing this window after Open Dental was already working properly, then this is a Windows permissions issue. Windows thinks that the current user signed into Windows does not have permission to access the shared network folder. But Windows is frequently wrong. Leave this window open. Separately, using Windows, browse to Network, and to the shared folder listed in this window, such as `\SERVER\OpenDentImages`. Windows will ask for username and password. Once you get that issue resolved, return to this window and click OK without changing anything.

The Edit Paths window identifies where Open Dental should store scanned or imported images and documents, export files, and store letter merge templates.

Verify all paths are accurate before pointing other computers to your server.

**A to Z Images Folder for storing images and documents**: Select where scanned or imported images and documents are stored *(A to Z Folder)(826)*.

Option 1. Store images and documents on a local or network folder:

1. Enter the path to the folder. This path will be used by all computers using the database.
   - If multiple computers access this folder, the path should point to a folder on a shared network. *(Share A to Z Folder)(828)*
   - If a single computer accesses this folder, the path can be local *(C:\OpenDentImages)*.
   - OpenDentImages is the default folder name that contains the A to Z folders, but any folder is valid as long as the A to Z folders are contained within it.
2. Use multiple paths: Not recommended for most users. If you select this option, you can enter multiple paths to the A to Z folders, separated by semicolon (no spaces). When Open Dental starts, the first valid path will be used. It can be used to run backups.

3. Path Override for this computer: If the path to the A to Z folders points to a shared folder on a network, and you need to override the path for this computer only, enter the override path.

Option 2. Store Images in Database(830): This option is not used often. If selected, images will be stored in the database and it will become very large. There will be no A to Z folders.


Option 4: Store images on a server via SSH File Transfer Protocol (SFTP): Store images on an FTP site using SFTP. An internet connection is required. Enter the following details:

- **AtoZ Path**: The folder that will store the images and documents. The default is AtoZ/
- **Hostname**: IP/ host name of the FTP server.
- **Username/Password**: FTP username and password.

Note: Port 22 is always used.

**Export Path**: The path to the folder where files exported from Open Dental are stored (e.g. Reports). It can be a local or network path. If the folder does not already exist, it will be created automatically when you export a report. The default folder is OpenDentalExports.

**Letter Merge Path**: The path to the folder where letter templates are stored for Letter Merge(1684). It can be a local or network path. If you enter a network path, make sure the folder is shared so all computers can access it. This folder must be created manually. The default folder name is OpenDentalLetters.

When you are done, click OK. If you do not enter a valid path for the A to Z folders, you will not be allowed to continue.

**Troubleshooting**

**Problem: The Edit Paths window comes up repeatedly when you start Open Dental.**

Solution: The path to the OpenDentImages (A to Z) folders is invalid. Enter a correct path that can be accessed by ALL computers ALL the time (e.g. a path that starts with \SERVER\ or similar).

A path to a mapped network drive (e.g Z:\OpenDentImages) is not recommended. Mapped drives must be set up on each computer and sometimes computers fail to properly remap the drive on startup. For example:

- If server has a dynamic IP address, an issue would arise every time the IP address changes at restart.
- DNS issues could cause problems linking the server name to the server IP address.
- If a permission path is set for the path to the server and Remember my credentials is not checked, issue could occur on restart.

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**A to Z Folder**
The A to Z folder is where Open Dental stores images and documents (see *Paths*(824)). Often they are scanned or imported in the *Images Module*(480). The A to Z folder consists of the following:

- 26 letter folders, labeled A through Z.
- Folders for email attachments, EOBs, forms, reports, sheet images and wiki images.
- Folders for SetupFiles (copies of all setup.exe versions used to install updates) and UpdateFiles (files copied during updates).
- Printed *Claim Form*(641) images.
- Saved logs from *Database Maintenance*(1434).

Note: The OpenDentImages folder may be called the OpenDentalData folder in older installations of Open Dental.

The default name of the A to Z folder is OpenDentImages. Below is what the file structure might look like if stored in a local or network folder.

Within each lettered folder are patient folders based on last name.
Each patient's folder is labeled by last name, first name and a unique number (Patient.PatNum in the database). Keeping all images for a patient within a single folder makes it easy to copy your files to other programs and to keep things organized. You have complete access to every file, but DO NOT move or rename them, because then Open Dental will be unable to find them. If a patient name changes (e.g. marriage) the folder name will not change; it will always remain the same as when the record was first created.

Images and documents stored in the A to Z folder are viewable in the Images module. If using Open Dental on multiple computers and storing files in a local or network folder, you will need to share the OpenDentImages folder (see Share A to Z Folder(828)). For shared network folder replication strategies, see Folder Replication.

Troubleshooting
Error: Could not find the path to the AtoZ folder.
Solution: Verify the data path to the A to Z folder is correct on the Data Paths window.

Problem: I upgraded to Windows 10 and can no longer access the shared OpenDentImages folder.
Solution: See the Troubleshooting section at the bottom of Share A to Z Folder(828).

Problem: My images are missing and/or I can't find them in the AtoZ folder.
Solution: Check for duplicated folders in your Open Dental directory. Click C: (or the drive Open Dental was installed on), Program Files (x86), Open Dental. Merge duplicated folders from the directory into the AtoZ folder.

Share A to Z Folder
See Paths(824).

If you are using Open Dental on multiple computers, you will need to share the A to Z Folder(826). The following instructions are for Windows 7 operating system. If your operating system is different, the steps may differ.
Note: These are steps for a SMB share. You can run it on a Linux box but it will add a level of complexity to network setup that may complicate future troubleshooting.

1. Right click on the OpenDentImages folder, then select Properties, Sharing tab.
2. Click Share.
3. Click the dropdown, select Everyone, then click Add.
4. Click the Read dropdown and select Read/Write.
5. Click Share.
6. Click Done.

The Network path on the OpenDentImages Properties window will read `\SERVER\OpenDentImages`.

It is a good idea to give permissions to `Everyone` in the Security tab as well.
1. Click the Security tab.
2. Click Edit.
3. Click Add.
4. Enter `Everyone` and click OK.
5. Check the Full control box.
6. Click OK.

**Troubleshooting**

**Problem:** I upgraded to Windows 10 and can no longer access the shared OpenDentImages folder.

**Solution:**
1. Confirm there is a password for the Windows server user name.
2. Reboot the server.
3. On each workstation, go to the File Explorer, then enter the server name as the path.
It should prompt you for a Windows server username and password.

4. Enter the Windows server user name and password, check **Remember my credentials**, then click OK.

**Store Images in Database**

Storing images directly in the database is one of three options available for storing scanned images and documents (Paths(824)). Most users will not use this option, but it is important for **Multi-tenant Hosting**.

**Notes:**

- To prevent users from accidentally switching to this method, a password is required (the password is *abracadabra*).
- The decision on which method to use should be made when you first start using Open Dental. If you switch back and forth between methods, various files and images will not follow.
- We do not recommend using **Replication** with images stored in database, except for distributions where the Images module is not used.

This table describes the different places where the **A to Z Folder**(826) are used and how the behavior differs when storing images directly in the database. This table has been ommitted.
Dropbox

You can use Dropbox to store your images off-site on the cloud.

In the **MainMenu** (592), click **Setup, Data Paths** (824).

Dropbox is one alternative to storing images and documents in the **A to Z Folder** (826). An internet connection is required. Be sure to address HIPAA-compliance issues. See **HIPAA**.

Note: Dropbox and SFTP were disabled in 16.3.47 and 16.4.19 due to extensive missing functionality. Missing functionality has been implemented in versions 17.1 and greater.

In the Edit Paths window above, select **Store images in Dropbox**.

Enter the folder in Dropbox that will store the images and documents. The default is **/AtoZ**.
Click **Authorize Dropbox** to set up a Dropbox account or authorize Open Dental access. A Dropbox sign in page will open in your default web browser.

- If you already have a Dropbox account, enter the email and password associated with the account and click Sign In.
- If you do not have a Dropbox account, click **New to Dropbox? Create an account** and follow the steps.

Once you are signed into the account, Dropbox will prompt you to allow Open Dental to access its folder in Dropbox.
Click Allow to permit access.

An access code will show on the screen. Enter it in the Enter Access Token box of the Authorize Dropbox window. You may need to minimize your browser to find the prompt. Click OK to save.

On the Edit Paths window, the Access Token will show.
Click OK to save and close the window.

Create a mirror copy of the A to Z folders in Dropbox, Apps, Open Dental. Refer to Dropbox Help Center for instructions.

- If using the Dropbox desktop application, add the folders to the Dropbox folder on your desktop and the folders will automatically sync.
- If using the Web version, only folders with contents can be copied. You may need to manually create empty folders.
Definitions
Definitions allow you to customize colors, list options, categories, and some defaults available on various windows.

In the Main Menu(592), click Setup, Definitions.
Definitions are grouped by category. Select a category to view its definitions and current settings. A short description of the category and what the definition controls show in the Guidelines section.

If a category controls list options, types, or categories, the Edit Items buttons are enabled.

**Add:** Add a new item to a category.

**Hide:** Hide an item. Select the item and click Hide. To unhide, double-click an item and uncheck Hidden in the Edit Definition window. Some items cannot be hidden or unhidden.

**Up/Down:** Move an item up or down in the list. Select an item and click Up or Down. This will also affect the sort order of the item in pick lists.

**Alphabetize:** Sorts the list alphabetically by definition name. Select a category and click Alphabetize. This will also affect the sort order of the item in pick lists.

### Add or Edit a Definition

To add or edit a category's definition:

Click Add or double-click an existing definition. The Edit Definition window will open.
Enter or select definition information. Available definition options differ depending on the category.

- If text can be edited, the text field will be white.
- If color is an option, click the colored block to select a Color.

Click OK to save.

**Color**

In Definitions edit, and some other windows, there is a colored square.

Click the square. The Windows color picker will allow you to choose a custom color.

**Basic colors:** Click on a color square to select it.

**Custom colors:** To change the color, drag the +, drag the arrow, or enter color values below. Custom colors cannot be saved.

Click OK to select the color and close the window.

**Troubleshooting**
If the right portion of the Color window doesn’t initially show, click Define Custom Colors.

If the color black will not select, choose a different color, click OK, then reopen the Color window and select black.

Definitions: Account Colors

In the **MainMenu** (592), click Setup, **Definitions** (835), Account Colors.

The Account Colors definition determines the text color of line items in the **Account Module** (150), Patient Account grid.

**Default:** Line items that are not listed below.

**Adjustments:** Text color of **Adjustments** (203).

**Discounts:** Text color of **Treatment Planned Procedure Discount** (292) adjustments.

**Patient Payments:** Text color of **Patient Payments** (158).
Insurance: Claims(208) with a status of waiting to send or sent.
Comm: Text color of Statements(269).
PayPlan: Payment Plan(239) debits and credits.
Insurance Payment: Text color of Claim Payments(231).
Received Ins Claim: Claims with a status of received.
Received Pre-Auth: Preauthorizations(293) with a status of received. Preauthorizations no longer show in the Account module, this definition is permanently hidden.
Broken Appointment Procedure: Procedure D9986 (missed appointment).
Canceled Appointment Procedure: Procedure D9987 (canceled appointment).

To edit a definition color double-click an item to open the Edit Definition window. Click the colored block to select a Color(837) then click OK to save. The item name cannot be changed or hidden.

Definitions: Account Procs Quick Add
In the MainMenu(592), click Setup, Definitions(835), Account Procs Quick Add.
The Account Procs Quick Add definition determines the list of items available in the Quick Procs (261) dropdown in the Account module.

To add or edit items available in the Quick Procs list:
1. Double-click an existing item or click Add to create a new item. The Edit Definition window will open.
2. **Name**: Enter the item name. This identifies the item in the Quick Procs dropdown. However, when the item is added to the patient's account, the procedure's description will be used.

3. **Procedure Codes**: Enter the procedure code or group of codes associated with the item. To enter more than one code, separate each code with a comma and do not add spaces (e.g. D0140,D0220). This field is case sensitive so enter the code as it appears in the Procedure Codes list.

4. Click OK to save.

To remove an item from the Quick Procs list, double-click the item and click **Delete**. If the item has been added to a patient's account it cannot be deleted. Hide the item instead.

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**Definitions: Adj Types**

In the **Main Menu**(592), click Setup, **Definitions**(835), Adj Types.
The Adj\Types definition determines the list of Adjust\ment(203) options available in the Account module and for various Module Preferences.

To add or edit available adjustment options:
1. Double-click an existing item or click Add to create a new item. The Edit Definition window will open.
2. **Name**: Enter the adjustment name. The name will appear on the patient accounts and statements when used.

3. Set the behavior of the adjustment.

   Enter + to create a positive adjustment that increases the patient balance. The adjustment will be listed under *Additions* in the *Adjustment* (203) Edit window.

   Enter - to create a negative adjustment that decreases the patient balance. The adjustment will be listed under *Subtractions* in the Edit Adjustment window.

   Enter dp to create an adjustment for a *Discount Plans* (1230).

   **Note**: Once the adjustment type is created, this value cannot be changed.

4. Click OK to save.

**Definitions: Appointment Colors**

In the *Main Menu* (592), click Setup, *Definitions* (835), Appointment Colors.
The Appointment Colors definition determines some of the colors in the Appointments Module.

**Practice Open**: Background color of the appointment schedule when the practice is open. This is the color shown when a provider is scheduled for an operatory. See Schedule Setup (1099).

**Practice Closed**: Background color of the appointment schedule when the practice is closed. This is the color shown when there is no scheduled provider for an operatory.

**Appointment Complete - Background**: Background color of completed appointments.

**Holiday**: Background color of the appointment schedule when the day is marked as a Holiday in Schedule Setup.

**Blockout Text**: Text color of blockouts.

**Patient Note Background**: Background color for patient notes not yet set complete (see Notes (320), Appointment Notes).

**Completed Pt Note Background**: Background color of patient notes that have been set complete.

To edit a definition color double-click an item to open the Edit Definition window. Click the colored block to select a Color (837) then click OK to save. The item name cannot be changed or hidden.
Definitions: Appt Procs Quick Add

In the Main Menu (592), click Setup, Definitions (835), Appt Procs Quick Add.

The Appt Proc Quick Add definition determines the list of procedures available in the Quick Add section of the Edit Appointment (20) window.

To add or edit items available in the quick add list:
1. Double-click an existing item or click Add to create a new item. The Edit Definition window will open.
2. Name: Enter the item name. This identifies the item in the quick add list. However, when the item is selected in the Edit Appointment window, the procedure’s description will be used.

3. ADA Code(s): Enter the procedure code or group of codes associated with the item. To enter more than one code, separate each code with a comma and do not add spaces (e.g. D0140,D0220). This field is case sensitive so enter the code as it appears in the Procedure Codes(1195) list.

   Note: Procedure codes cannot be added if they require a treatment area other than mouth (i.e. arch, tooth, etc.)

4. Click OK to save.

Definitions: Auto Deposit Account

In the MainMenu(592), click Setup, Definitions(835), Auto Deposit Account.
The Auto Deposit Account definition determines the account options available when creating automatic Deposit Slip while finalizing insurance payments.

To add or edit items available in the Auto Deposit Account list:
1. Double-click an existing item or click Add to create a new item. The Edit Definition window will open.
2. **Name**: Enter the item name. This identifies the item in the Auto Deposit Account dropdown in the Edit Insurance Payment window.

3. **Account Number**: The deposit account number.

4. Click OK to save.

To remove an item from the Auto Deposit Account list, double-click the item and click **Delete**. If the item has been attached to an insurance payment it cannot be deleted. Hide the item instead.

**Definitions: Auto Note Categories**

In the [Main Menu](592), click Setup, [Definitions](835), Auto Note Categories.
The Auto Note Categories definition determines which category folders are available to organize Auto Notes (317).

Categories can be nested within each other. If a category is nested in another category, its parent will list under the Parent Category. For example, in the image above, Hygiene is nested in Comp Exam which is nested in New Patient Exam. This results in the following auto note category structure:

To change the order of the categories as viewed in the auto note window, go to Setup, Auto Notes. Changing the order in the Definitions window does not change the view in the Auto Notes window.

To add or edit category folders:
1. Double-click an existing item or click Add to create a new item. The Edit Definition window will open.
2. **Name:** Enter the category folder name.

3. (Optional) To add the category to another category, click the picker button [...] then choose the parent category from the Definition Picker window. Categories can also be nested from the Setup, Auto Notes window. In the example below, Comp Exam will be nested under New Patient Exam.

4. Click OK to save.

To remove a category from another category, double-click the item and click the red X. To remove a category all together, double-click the item and click **Delete**. Auto notes in deleted categories will not be deleted.

**Definitions: Billing Types**

In the **Main Menu**(592), click Setup, **Definitions**(835), Billing Types.
The Billing Types definition determines the billing type options available in the Edit Patient Information(62) and Edit Insurance Plan(81) windows.

Create billing types to indicate how a patient is to be billed (e.g. email statements, send to collections, etc).

To add or edit available billing type options:
1. Double-click an existing item or click Add to create a new item. The Edit Definition window will open.
2. **Name:** Enter the billing type name.

3. Set the behavior of the billing type.

   - Enter **E** to email statements to patients assigned this billing type. Statements will be emailed when sent from the Billing List(507).

   - Enter **C** for use with patient accounts sent to **TSI**(527) for collections.
     
     Note: If multiple C billing types have been created, only guarantors assigned the first in the list will be included in the TSI Sent Accounts(530) tab. Using a single C billing type is recommended, and it should not be added to a preexisting billing type already in use.

   - Enter **CE** for use with patients excluded from **TSI**(527) collections.
     
     Note: If multiple CE billing types have been created, only guarantors assigned the first in the list will be included in the TSI Excluded Accounts(532) tab. Using a single CE billing type is recommended, and it should not be added to a preexisting billing type already in use.

   - Leave blank for standard billing. Statements will be printed to be mailed or sent electronically if Electronic Billing(514) is enabled.

4. Click **OK** to save.

While billing types may be hidden, if in use the billing type will still be visible in various areas throughout the program. If the New patient primary insurance plan sets patient billing type, Family Module Preferences(637) is checked, creating a new insurance plan will still change the patient's billing type to the hidden billing type.

**Definitions: Blockout Types**

In the Main Menu(592), click Setup, Definitions(835), Blockout Types.
The Blockout Types definition determines the available Blockouts(10) to use in the Appointments Module(1) and the blockout background color.

Note: Requires the Setup, security permission (see Permissions(1118)).

To Use solid blockouts instead of outlines on the appointment book, check the Appointment Module Preference(608). To change the Blockouts(10) text color, see Definitions: Appointment Colors(843).

To add or edit available blockout types:
1. Double-click an existing item or click Add to create a new item. The Edit Definition window will open.
2. **Name**: Enter the blockout name. This will show on the appointment schedule.

3. (Optional) Set the **Usage** of the blockout type. Usage selections are abbreviated in the Flags column of the definitions grid.

   **Block appointments scheduling**: When checked, prevents appointments from being scheduled over this blockout type (NS flag).

   **Disable Cut/Copy/Paste**: When checked, disables the cut, copy, and paste functions for this blockout type (DC flag).

4. Click the colored block to select a blockout **Color** (837).

5. Click OK to save.

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**Definitions: Carrier Group Names**

In the **MainMenu** (592), click Setup, **Definitions** (835), Carrier Group Names.
The Carrier Group Names definition determines the group options available in the carrier group dropdown when adding or editing Insurance Carriers (1237).

To add or edit a definition, click Add or double-click an item to open the Edit Definition window. Enter the carrier group Name and click OK to save.

Definitions: Chart Graphic Colors
In the Main Menu (592), click Setup, Definitions (835), Chart Graphic Colors.
The Chart Graphic Colors definition determines the colors used on the [Graphical Tooth Chart](#).(464).

**Treatment Planned, Complete, Existing Current Prov, Existing Other Prov, Referred Out**: Graphic colors for procedures charted with these statuses. Colors selected for these statuses (and light) will also show as default choices on the [Draw Tab](#)(332).

**Treatment Planned (light), Complete (light), Existing Current Prov (light), Existing Other Prov (light), Referred Out (light)**: Graphic colors for procedures charted with these statuses and with a procedure paint type, light (see [Add Procedure Code](#)(1204)).

**Main Background**: Background color of the tooth chart.

**Text**: Color of the tooth number text.

**Highlighted Text**: Color of the tooth number text when tooth is selected.

**Highlighted Background**: Background color of the tooth number when the tooth is selected.

**Background on TPs**: Background color of the tooth chart on signed and printed [Treatment Plans](#)(283).

**Text on TPs**: Color of the tooth number text on signed and printed treatment plans.

**Condition**: Graphic color for procedures when charted as a condition.

**Condition (light)**: Graphic color for procedures when charted as a condition and with a procedure paint type, light.
To edit a definition color double-click an item to open the Edit Definition window. Click the colored block to select a Color then click OK to save. The item name cannot be changed or hidden.

If the graphic color is changed for a procedure status, consider also changing the procedure text color in the progress notes to match. See Definitions: Prog Note Colors.

Definitions: Claim Custom Tracking

In the MainMenu, click Setup, Definitions(835), Claim Custom Tracking.

The Claim Custom Tracking definition determines the list of claim tracking statuses available on the Edit Claim - Status History Tab(219).
Use custom statuses to filter the Outstanding Insurance Claims Report by status and to exclude claims from the report for a certain number of days after a status is changed. Set the number of days in this definition. None is the default tracking status. To remove None as an option check the Account Module Preferences, Exclude 'None' as an option on Custom Tracking Status, the first status in the definitions list will be used as default instead.

To add or edit available claim tracking status options:
1. Double-click an existing item or click Add to create a new item. The Edit Definition window will open.

2. Name: Enter the claim tracking status.
3. Days Suppressed: Enter the number of days to exclude a claim from the outstanding insurance claims report for this status.
4. Click OK to save.

To remove an item from custom tracking status lists, double-click the item and click Delete. If the item has been used it cannot be deleted.

Definitions: Claim Error Code
In the MainMenu, click Setup, Definitions, Claim Error Code.
The Claim Error Code definition determines the list of error code options available in the Edit Claim - Status History Tab (219).

To add or edit available claim error code options:
1. Double-click an existing item or click Add to create a new item. The Edit Definition window will open.
2. **Name**: Enter the abbreviation for the error code. This will show in the Error Code column of the Claim Custom Tracking Status History grid.

3. **Description**: Enter the full description of the error code.

4. Click OK to save.

To remove an item from the claim error code list, double-click the item and click **Delete**. If the item has been used it cannot be deleted.

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**Definitions: Claim Payment Groups**

In the **Main Menu**(592), click Setup, **Definitions**(835), Claim Payment Groups.
The Claim Payment Group definition determines the list of payment group options available when finalizing insurance payments or entering batch insurance payments.

Payment groups are useful for large enterprise organizations who have multiple people entering payments at once. The Daily Payments report can be filtered by claim payment group.

To add or edit a claim payment group option, click Add or double-click an item to open the Edit Definition window. Enter the payment group **Name** then click OK to save.

**Definitions: Claim Payment Tracking**

In the **Main Menu** (592), click Setup, **Definitions** (835), Claim Payment Tracking.
The Claim Payment Tracking definition determines which payment tracking options are available for Claim procedures (claim procs).

To add or edit a payment tracking option, click Add or double-click an item to open the Edit Definition window. Enter the tracking Name then click OK to save.

Definitions: Clinic Specialties
In the Main Menu, click Setup, Definitions, Clinic Specialties.
The Clinic Specialties definition determines the list of specialty options available to assign to a Clinic (1224) or patient in the Edit Patient Information (62) window.

Specialties are useful when used to differentiate Patient Clones (145).

To add or edit a specialty option, click Add or double-click an item to open the Edit Definition window. Enter the specialty Name then click OK to save.

**Definitions: Commlog Types**

In the Main Menu (592), click Setup, Definitions (835), Commlog Types.
The Commlog Types definition determines the options available in the Commlog(1654) type list.

This also assigns the default Commlog(1654) type for some processes that automatically create commlogs in this definition (e.g. recall, texting, etc.).

Note: eServices will use the first commlog type in the list.

To add or edit available commlog types:
1. Double-click an existing item or click Add to create a new item. The Edit Definition window will open.
2. **Name**: Enter the commlog type.

3. **Usage**: (Optional) Set the default commlog type when a commlog is automatically generated. Only assign one default per type. If no default is set, the first type in the list will be used.
   - **APPT**: Enter APPT to set this as the default type when Comm is clicked on the Edit Appointment(20) window. Commlogs with this type are highlighted yellow in the Communications Log - Appointment Scheduling grid.
   - **FIN**: No longer used in the program.
   - **RECALL**: Enter RECALL to set this as the default type when a recall status is selected from the Set Status dropdown or Comm is clicked on the Recall List(27).
   - **MISC**: Enter MISC to set this as the default type when Commlog is clicked from the Main Toolbar(1649).
   - **TEXT**: Enter TEXT to set this as the default type when a Text Message(1675) is sent.
   - **REACT**: Enter REACT to set this as the default type when using the Reactivation List(33).

4. **Color**: Click to assign color to the text of the commlog.

5. Click OK to save.

To hide a commlog type, check **Hidden**.

Editing existing commlog types will change the type on current commlog entries.

**Definitions: Contact Categories**

In the Main Menu(592), click Setup, Definitions(835), Contact Categories.
The Contact Categories definition determines the category options for Contacts (1227).

To add or edit a contact category, click Add or double-click an item to open the Edit Definition window. Enter the category Name then click OK to save.

Definitions: Diagnosis Types

In the Main Menu (592), click Setup, Definitions (835), Diagnosis Types.
The Diagnosis Type definition determines the list of diagnosis options available when Entering Treatment (301).

To add or edit available diagnosis options:
1. Double-click an existing item or click Add to create a new item. The Edit Definition window will open.
2. **Name**: Enter the diagnosis.

3. **1 or 2 letter abbreviation**: Enter a short abbreviation for the diagnosis. The abbreviation will show in the Chart Module (298) progress notes.

4. Click OK to save.

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**Definitions: Fee Colors**

In the Main Menu (592), click Setup, Definitions (835), Fee Colors.
The Fee Color definition determines the text color of global fees, provider-specific fees, clinic-specific fees, and provider/clinic-specific fees in the Procedure Codes (1195) window.

To edit a definition color double-click an item to open the Edit Definition window. Click the colored block to select a Color (837) then click OK to save. The item name cannot be changed or hidden.

Definitions: Image Categories
In the MainMenu (592), click Setup, Definitions (835), Image Categories.
The Image Categories definition determines the category folders available to organize documents in the Images Module (480).

Also with this definition, set category images to show in other areas of the program and set the default category where documents are saved (e.g. saved treatment plans, statements, etc).

To add or edit category folders:
1. Double-click an existing item or click Add to create a new item. The Edit Definition window will open.
2. **Name**: Enter the category name.

3. **Usage**: (Optional) Set the category properties by checking the boxes that apply.
   - **Expanded by default**: Check to set the category to expand and show all files by default. To set this per user, check Document tree folders persistent expand/collapse per user in Images Module Preferences (740).
   - **Show in Chart module**: Check to show this category and the images in the Chart Module (298). The category will appear as an additional tab at the bottom of the Chart. Double-click a thumbnail to open the document. Only image files will have a thumbnail preview.
   - **Show in Patient Forms**: Check to access documents in this category from the Patient Forms (1690). Double-clicking a document in the forms window will immediately switch to the document in the Image module.
   - **Show in Patient Portal**: Check to let patients access documents in this category from the Patient Portal Feature.
   - **Patient Pictures (only one)**: Check to use images stored in this category as the patient picture in the Family Module (59) and on the Appointments Module (1).
   - **Statements (only one)**: Check to store PDF copies of all printed and emailed Statements (269) in this category.
   - **Graphical Tooth Charts (only one)**: Check to store tooth charts saved from the Chart module in this category.
   - **Treatment Plans**: Check to store PDF copies of printed or emailed treatment plans from the Treatment Plan Module (283) in this category.
   - **Payment Plans (only one)**: Check to store PDF copies of printed payment plans. See Sign and Print Payment Plan (243) in this category.
   - **Claim Attachments (only one)**: Check to store attachments from DentalXChange Attachment Service (215)

4. Click OK to save.

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**Definitions: Insurance Filing Code Group**

In the **Main Menu** (592), click Setup, **Definitions** (835), Insurance Filing Code Group.
The Insurance Filing Code Group definition determines the categories available to organize Insurance Filing Codes.

To add or edit a group option, click Add or double-click an item to open the Edit Definition window. Enter the group Name then click OK to save.

Definitions: Insurance Payment Types

In the Main Menu, click Setup, Definitions, Insurance Payment Types.
The Insurance Payment Types definition determines the payment type options available when Finalizing Insurance Payments (231).

Also set which payment types to exclude when creating a Deposit Slip (516). The Daily Payments Report (1294) is grouped by insurance payment type and can optionally be filtered by type.

To add or edit available payment type options:
1. Double-click an existing item or click Add to create a new item. The Edit Definition window will open.
2. **Name**: Enter the payment type.
3. **N=Not selected for deposit**: Enter N to exclude this type from deposit slips or leave blank to include this type.
4. Click OK to save.

To remove an item from the Payment Type list, double-click the item and click **Delete**. If the item has been attached to an insurance payment it cannot be deleted.

**Definitions: Insurance Verification Status**

In the [Main Menu](592), click Setup, Definitions(835), Insurance Verification Status.
The Insurance Verification Status definition determines the status options available in the Insurance Verification List (49).

To add or edit a definition, click Add or double-click an item to open the Edit Definition window. Enter the status name and click OK to save.

**Definitions: Letter Merge Cats**

In the Main Menu (592), click Setup, Definitions (835), Letter Merge Cats.
The Letter Merge Cats definition determines the categories options available for the Letter Merge feature.

To add or edit a definition, click Add or double-click an item to open the Edit Definition window. Enter the category Name and click OK to save.

Definitions: Misc Colors

In the Main Menu, click Setup, Definitions, Misc Colors.
The Misc Colors definition determines the colors used in various areas of the program.

**Family Module Coverage**: Background color of insurance subscriber information.

**Perio Bleeding**: Color of the bleeding indicator in the Perio Chart (382).

**Perio Suppuration**: Color of the suppuration indicator in the perio chart.

**Chart Module Medical**: Background color of the medical chart grid under patient info in the Chart Module (298). See Medical (466).

**Perio Plaque**: Color of the plaque indicator in the perio chart.

**Perio Calculus**: Color of the calculus indicator in the perio chart.

**Chart Today's Proc**: Background color of procedures scheduled for today in the Chart module.

**Commlog Appt Related**: Background color of commlog entries in the Edit Appointment (20) window (only when created from this window).

**Family Module Referral**: Background color of the Referred To/Referred From/Custom Referral fields in the patient information area of the Family Module (59).

**Family Module ICE**: Background color of the ICE Name/ICE Phone fields in the patient information area of the Family module.
**Family Module Pat Restrictions**: Background color of the Pat Restrictions field in the patient information area of the Family module.

To edit a definition color double-click an item to open the Edit Definition window. Click the colored block to select a color then click OK to save. The item name cannot be changed or hidden.

### Definitions: Payment Plan Categories

In the **Main Menu** (592), click Setup, **Definitions** (835), Payment Plan Categories.

![Payment Plan Categories](image)

The Payment Plan Categories determine the list of category options available in the **Payment Plan** (239) window.

Assign a category to a patient or an insurance Payment Plan to distinguish one plan from another in a family with multiple payment plans. If no category is created, all payment plans will default to None.
To add or edit a definition, click Add or double-click an item to open the Edit Definition window. Enter the category **Name** and click OK to save.

**Definitions: Payment Types**

In the **Main Menu** (592), click Setup, **Definitions** (835), Payment Types.

The Payment Types definition determines the list of patient payment type options available in the **Edit Payment** (153) window.

Also set which payment types to exclude when creating a **Deposit Slip** (516). The **Daily Payments Report** (1294) is grouped by patient payment type and can optionally be filtered by type.
To add or edit available payment type options:
1. Double-click an existing item or click Add to create a new item. The Edit Definition window will open.

2. **Name**: Enter the payment type.
3. **N=Not selected for deposit**: Enter N to exclude this type from deposit slips or leave blank to include this type.
4. Click OK to save.

Note: If a *Cash* payment type does not exist, one will be automatically created for use in Deposit Slips (516). If you have been using a different payment type to track cash payments, you must change them to the *Cash* payment type in order to track money payments in a deposit.

**Definitions: PaySplit Unearned Types**

In the **Main Menu** (592), click Setup, **Definitions** (835), PaySplit Unearned Types.
The PaySplit Unearned Type definition determines the list of Unearned(191) Type options available in the Paysplit(161) window.

By default, the Prepayment unearned type is used when a payment is posted to an account with a credit or no balance and when the Prepay button is clicked in the payment window. To change the default type, see the Default unearned type for unallocated paysplits in Account Module Preferences(693).

To add or edit a definition, click Add or double-click an item to open the Edit Definition window. Enter the unearned type Name then click OK to save.

Do Not Show on Account: These prepayment types do not show on the account ledger, on statements, or most reports. They are primarily used when a prepayment is associated with a treatment planned procedure. If a patient has one of these prepayments, the Hidden Splits(276) tab will show in the Account Module(150). To change the default type, see Default Treatment Planned Procedure Unearned Type in Account Module Preferences.
Definitions: Proc Button Categories

In the **Main Menu**(592), click Setup, **Definitions**(835), Proc Button Categories.

The Proc Button Category definition determines the category options available to group procedure code buttons in the **Chart Module**(298).

Also edit categories or assign procedures to a category in the **Procedure Button Setup**(736).

To add or edit a definition, click **Add** or double-click an item to open the Edit Definition window. Enter the category **Name** then click OK to save.
Definitions: Proc Code Categories

In the Main Menu(592), click Setup, Definitions(835), Proc Code Categories.

The Procedure Code Category definition determines the category options available to group the list of Procedure Codes(1195).

Assign procedure codes to categories in the Edit Procedure Code Window(1200).

To add or edit a definition, click Add or double-click an item to open the Edit Definition window. Enter the category Name then click OK to save.
Definitions: Prog Note Colors

In the Main Menu(592), click Setup, Definitions(835), Prog Notes Colors.

The Prog Notes Colors definition determines the text and background colors for various progress note entry types in the Chart Module(298).

To edit a definition color double-click an item to open the Edit Definition window. Click the colored block to select a Color(837) then click OK to save. The item name cannot be changed or hidden.

If a progress note entry color is changed, consider also changing the corresponding chart module graphic color to match. See Definitions: Chart Graphic Colors(855).
• **Status Treatment Planned**: Treatment Planned Procedures (303).
• **Status Complete**: Completed Procedures.
• **Status Existing Current Prov**: Procedures marked Existing, Current Provider.
• **Status Existing Other Prov**: Procedures marked Existing, Other Provider.
• **Status Referred**: Procedures marked as Referred out to a specialist.
• **Rx**: Prescriptions (333).
• **CommLog**: CommLogs (1654).
• **LabCase**: LabCases (379).
• **Appointment Text - Today**: Text in Appointments (1) for the current date.
• **Appointment Background - Today**: Background in Appointments for the current date.
• **Past Appointment Text**: Text in prior appointments.
• **Past Appointment Background**: Background in prior appointments.
• **Future Appointment Text**: Text in scheduled appointments for a future date.
• **Future Appointment Background**: Background of scheduled appointments for a future date.
• **Broken/Unsched Appt Text**: Text in Broken Appointments, or those added to the Unscheduled List (41).
• **Broken/Unsched Appt Background**: Background in Broken Appointments, or those added to the Unscheduled List.
• **Planned Appointment Text**: Text in Planned Appointments (325)
• **Planned Appointment Background**: Background in Planned Appointments.
• **Patient Note Text**: Text in Patient attached Appointment Module Notes (320), as displayed in the Chart module.
• **Patient Note Background**: Background in Patient attached Appointment Module Notes, as displayed in the Chart module.
• **Completed Pt Note Text**: Text in Patient attached Appointment Module Notes marked complete, as displayed in the Chart module.
• **Completed Pt Note Background**: Background in Patient attached Appointment Module Notes marked complete, as displayed in the Chart module.
• **Status Condition**: Charted Conditions.

Definitions: Prognosis

In the **Main Menu** (592), click Setup, Definitions (835), Prognosis.
The Prognosis definition determines the list of prognosis options available when Entering Treatment (301).

To add or edit a definition, click Add or double-click an item to open the Edit Definition window. Enter the prognosis Name then click OK to save.

**Definitions: Provider Specialties**

In the Main Menu (592), click Setup, Definitions (835), Provider Specialties.
The Provider Specialties definition determines the list of specialty options available in the Provider Setup(1255) and Edit Referral(1268) windows.

To add or edit a definition, click Add or double-click an item to open the Edit Definition window. Enter the specialty Name then click OK to save.

Note: Editing the existing specialties may affect E-Claims(645).

Definitions: Recall / Unsched Status

In the Main Menu(592), click Setup, Definitions(835), Recall/Unsched Status.
The Recall/Unsched Status definition determines the Set Status/Unscheduled Status options available in the Recall (27) and Unscheduled Lists (41).

When a status is selected from the Set Status dropdown menu in the recall list, a Commlog (1654) is created with the status name. In the unscheduled list, selecting a status from the Unscheduled Status dropdown in the Edit Appointment (20) window changes the UnschedStatus column.

To add or edit available status options:
1. Double-click an existing item or click Add to create a new item. The Edit Definition window will open.
2. **Name**: Enter the status.
3. **Abbreviation**: Enter the status abbreviation. Must be 7 characters or less.
4. Click OK to save.

**Definitions: Regions**

In the [Main Menu](592), click Setup, [Definitions](835), Regions.
The Regions definition determines the list of regions options available to assign to Clinics (1223). This helps identify clinics and can be used to filter the Insurance Verification List (49).

To add or edit a definition, click Add or double-click an item to open the Edit Definition window. Enter the region Name then click OK to save.

Definitions: Supply Categories

In the Main Menu (592), click Setup, Definitions (835), Supply Categories.
The Supply Categories definition determines the category options available to group Supplies(524).

To add or edit a definition, click Add or double-click an item to open the Edit Definition window. Enter the category Name then click OK to save. To remove a category not in use, double-click the item and click Delete.

Definitions: Task Priorities

In the Main Menu(592), click Setup, Definitions(835), Task Priorities.
The Task Priorities definition determines the priority status options available to assign to Tasks (1695).

The priority determines the task color and sort order in Task Lists (1705).

To add or edit available priority options:
1. Double-click an existing item or click Add to create a new item. The Edit Definition window will open.
2. **Name**: Enter the priority status.
3. **D = Default, R = Reminder**: Set the priority default.
   - Enter **D** to designate the default priority for all newly created tasks (only one can be flagged as default).
   - Enter **R** to designate the default Task Reminder (1701) priority.
4. Click the colored block to select the task background **Color** (837) for this priority.
5. Click OK to save.

**Definitions: Treat' Plan Priorities**

In the **Main Menu** (592), click Setup, **Definitions** (835), Treat' Plan Priorities.
The Treat' Plan Priorities definition determines the priority options available to assign Procedure(303) codes.

Assign a priority to a procedure in the procedure info window, Treatment Plan Module(283), or Chart Module(298) progress notes. Set the order of priorities in this definition. The priority affects the order of procedure codes in the Edit Appointment(20) window and progress notes, as well as the order and procedure text color on treatment plans.

To add or edit a definition, click Add or double-click an item to open the Edit Definition window. Enter the priority Name and select the procedure text Color(837) associated to the priority. Click OK to save.

Definitions: Web Sched New Patient Appt Types

In the Main Menu(592), click Setup, Definitions(835), Web Sched New Pat Appt Types.
The Web Sched New Pat Appt Types definition determines the list of available Reasons for Appointment options patients select from when scheduling an appointment using the Web Sched New Patient (1586) feature.

Create Appointment Types (619) first to determine the length and procedures for certain types of appointments. Then assign a Web Sched New Pat Appt Type to the appointment type. When a patient schedules an appointment online and selects one of these types from the list of appointment reasons, an appointment will be created with the procedures and for the length designated in the associated appointment type.
To add or edit the reasons for appointment:
1. Double-click an existing item or click Add to create a new item. The Edit Definition window will open.

2. **Name**: Enter the reason. The reason text is also added to the appointment note.
3. **Appointment Type**: Click [...] to assign an appointment type. Each reason can be assigned to one appointment type.
4. Click OK to save.

To delete a reason not in use, double-click an item and click **Delete**.

**Dental School Setup**

In the **Main Menu** (592), click Setup, Dental Schools.

The Dental Schools feature in Open Dental assists large dental or hygiene schools track students.
To turn on dental school features, in the **Main Menu**(592), click Setup, Advanced Setup, **Show Features**(806). Check the box for Dental Schools.

An important **Dental School Security**(1120) issue is making sure all users are assigned to a user group. User groups determine a user's security permissions. To automate this process, you can assign default user groups for instructors and students.

**Students**: Click [...] to select the user group that will be assigned to all students.

**Instructors**: Click [...] to select the user group that will be assigned to all instructors.

Click **OK** to save your changes.

The user group can also be changed individually. See **Security**(1106).

To setup classes, see **Dental School Classes**(1232).

To setup courses, see **Dental School Courses**(1233).

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**Dental School Evaluation Setup**

In **Dental School Setup**(896), click **Evaluations**.

Setting up **Dental Student Evaluations**(1439) for **Dental Schools**(808) includes attaching a grading scale and defining the criteria that will be evaluated. To set up evaluations, the logged on user must have the **Setup** security permission. The list of evaluation definitions can be filtered by dental course.

Click **Add**, or double-click an existing evaluation definition.
Reorder criteria using the Up/Down arrows. If using a weighted grading scale, the total points for all criteria shows at the bottom.

Enter general evaluation information.
- **Title**: The identifying name of this evaluation.
- **Grading Scale**: Click [...] to attach a grading scale. See Dental School Grading Scales (899).
- **Course**: Click [...] to attach this evaluation to a dental course.

**Add the criteria that will be part of the evaluation.**
1. Click Add.

2. Enter the criteria, then click OK to save.
   - **Description**: The identifying name of the criteria.
Grading Scale: The scale that will be applied to this criteria. By default, the scale of the evaluation is selected. Click [...] to change. The overall grade calculation will be always be based on the evaluation's grading scale.

Points: Only shows if using a weighted grading scale. Enter the maximum number of points possible for this criteria.

Is Category Name: Check this box to use this criteria as a header in the evaluation. No points or grades will be associated with this row; it will be for organization purposes only.

3. Repeat this step to add all criteria to the evaluation.

Dental School Grading Scales

In Dental School Setup(896), click Grading Scales.

Dental School(808) grading scales are attached to Dental Student Evaluations(1439) to calculate a grade. To set up grading scales, the logged on user must have the Setup security permission.

Click Add, or double click an existing grading scale to edit.
Enter an identifying description.

Select the type of grading scale. There are three options:
- Percentage: Assumes a 0 – 100% grading scale. Instructors will manually enter percentages when filling out an evaluation.
- Weighted: Used to assign different values (e.g. points) to evaluation criteria. Instructors will manually enter values when setting up an evaluation.
- Pick List: Grading scale will contain a list of pick-able items (e.g. A, B, C, D, F). See step 5.

If Pick List is the grading scale type, enter the pick list items:
1. Click Add.
   - [Image of the grading scale item edit window]
   2. Enter the grading item details, then click OK to save.
      - Grade Showing: What shows for the student (e.g. A, B, C, D, F).
      - Grade Number: The number value associated with the grade.
      - Description: A description of the grade and value.

Repeat for each pick list item.

Click OK to save the grading scale.

Display Fields
This lets you customize which fields of information show in various areas, field size, and the order in which they show.

In the Main Menu (592), click Setup, Display Fields.
Categories:

**A/R Manager Sent Grid**: For TSI users only. Determines the columns in the TSI A/R Manager for sent accounts grid. See [TSI Collections](527).

**A/R Manager Unsent Grid**: For Transworld Systems users only. Determines the columns in the TSI A/R Manager for unsent accounts grid.

**Account Module**: Columns in the [Account Module](150), Patient Account grid.

**Account Patient Information**: Determines if a patient information area displays in the Account Module, and the fields that show. This area will not show at all if no fields are listed under Fields Showing.

**Appointment Bubble**: Information that shows in the popup bubble when you hover over an appointment in the schedule.

**Appointment Edit**: Columns in the Procedures on this Appointment grid in the [Edit Appointment](20).

**Chart Patient Information**: Fields in the Chart Module, Patient Info area.

**Family Recall Grid**: Columns in the Family Module, Recall grid.

**Ortho Chart**: Columns in the lower grid of the Ortho Chart window. This setup is different than other display fields. See [Ortho Chart](390).

**Outstanding Ins Report**: Columns in the [Outstanding Insurance Claims Report](1315).

**Patient Information**: Rows in the Family Module, Patient Information area.

**Patient Search**: Determines fields available in CEMT Patient Search.

**Patient Select**: Columns in the [Select Patient grid](1649).

**Planned Appointment Edit**: Columns available in the Edit Planned Appointment window

**Procedure Group Note**: Columns in the Procedures List when adding a [Procedure Group Note](479).

**Recall List**: Columns in the [Recall List](27).

**Statement Main Grid**: Columns in the StatementMain grid when [Statement Layout](1186).
**Treatment Plan Module**: Columns in the Treatment Plan Module, Procedures list, on saved and printed Treatment Plans, and in the TreatPlanMain grid when Treatment Plan Layout (1188).

Chart Module progress notes can be customized using the Show tab.

Double-click a category to customize the information that shows.

Select which fields to show by moving fields between Available Fields and Fields Showing. Highlight the fields then click the left or right arrows in the middle of the window.

- **Fields Showing**: All fields currently showing in the category.
- **Available Fields**: A list of fields that can be added to the category. Fields will vary depending on the category. For a description of some fields, see Available Fields below.
- **Set to Default**: Return all Fields Showing to the default. This will remove any fields that have been added.

Double-click on a Fields Showing field to change its properties.
**Internal Name**: The name of the field in Open Dental code. This value cannot be changed.

**New Description**: The label that will identify this field in the interface.

**Minimum Width**: A fixed minimum column width based on the New Description length.

**Column Width**: The maximum allowed width of the column. This is designed to allow the Language translation feature to work better when foreign words are longer.

To change the order of fields, click the up/down arrows.

We continue to expand this feature by adding more grid types and more column fields. If there are other grids or fields that you are interested in, please submit a feature request.

**Available Fields**

Most fields that list under Available fields are self explanatory. Below are a few that need additional explanation.

**Allowed**: Used in the Treatment Plan Module. The PPO fee for PPO plans or the allowed fee for out of network plans.

**ABC0**: Used in Chart Patient Information and Patient Information. Indicates the patient's credit rating or other personal attributes discreetly in the Patient Information grid.

**Broken Appts**: Used in Chart Patient Information. Displays the number of broken appointments a patient has. The count is based on the broken appointment procedure (D9986) if it exists in the Procedure Code List, or if it doesn't exist, adjustments with a broken appt type.

**Clinic**: Used in multiple categories. The clinic abbreviation.

**ClinicDesc**: Used in Account Patient Information and Chart Patient Information. The clinic description set.

**Date Bal Began**: Used in the AR Manager Sent, Unsent, and Excluded Grids. Date a patient's balance began.

**Days Bal Began**: Used in the AR Manager Sent, Unsent, and Excluded Grids. How many days ago a patient's balance began.

**Discount Plan**: Used in the Appointment Bubble. Adds the name of the patient's Discount Plan (1230).

**DPlan**: Used in the Treatment Plan Module. Indicates the discount amount when the patient has a discount plan.

**Estimated Patient Portion**: Used in the Appointment Bubble. Estimated patient portion for attached procedures. (patient portion = gross production - estimated insurance write-offs + adjustments - insurance estimates).

**Invoice Number**: Used in the Patient Select. Invoices automatically generate a unique invoice number. Use the invoice number to search for a patient.

**InvoiceNum**: Used in the Statement Main Grid. Invoices automatically generate a unique invoice number to show on invoices.

**Last Proc**: Used in AR Manager Sent, Unsent, and Excluded Grids. Date of last completed procedure for the family.
**Pat Fields:** Used in Account Patient Information, Chart Patient Information, and Patient Information. Adds all Patient Fields (687).

**Patient Portal:** Used in Chart Patient Information. Indicates if patient has been granted access to the Patient Portal. Double-click this field to Grant Access (1560) or generate new passwords.

**Pat Restrictions:** Used in Patient Information. Lists restrictions associated to the selected patient (e.g. appointment scheduling).

**Referral:** Used in the Patient Information area. Indicates when a patient has a referral source (to, from, or custom). The label for custom referrals is determined by the New Description text. The Referred From and Referred To labels cannot be changed.

**Signed:** Used in the Account Module. Indicates when an item has been electronically signed (e.g. procedures, consent forms).

**Tobacco Use:** Used in Chart Patient Information. Indicates a patient's tobacco use history (up to three of the most recent assessments). Double-click to open the Tobacco Use window and assess status. EHR Tobacco (455)

**Specialty:** Used in Chart Patient Information. Used for differentiating patient clones.

**Enterprise Setup**

In the Main Menu (592), click Setup, Enterprise.
Many of these settings appear in other locations in Open Dental, but changes in either place will reflect globally. Enterprise Setup must be turned on in Show Features (806).

Note: Some grayed out options can only be enabled via a query. Others can be set elsewhere in Open Dental. See details below. Contact Support for assistance.

**Account Tab**

**Aging calculate monthly instead of daily**: Check to have aging calculated on a monthly basis. This is an old method that was retained for backwards compatibility. It is not recommended. If selected, you must manually update aging by running the aging tool (see below). Aging in a patient's Account will be based on the last calculated date. The last calculated date will also be the default in the Aging of A/R report, though can be changed.

**Aging for enterprise Galera cluster environments using FamAging table**: Only used by enterprise organizations that
use Galera cluster environments to prevent possible deadlocks when running Aging(1423). Must be set from Miscellaneous Setup(921).

- Checked: A password is required to check this box; it is *abracadabra*. When checked, aging will only calculate once per day and a second field labeled **DateTime the currently running aging started** will show.

   ![Aging for enterprise Galera cluster environments using FAM Aging table](checkmark)

   **DateTime the currently running aging started**

   [Usually blank] Clear

   If aging is running, the date and time it started will appear and clear once aging is completed. As long as there is a value in the field, another person cannot run aging simultaneously (thus preventing possible deadlock). To clear the value (e.g. to allow another person to run aging), press Clear. This is rare and typically only done if aging started on a computer that was forcefully closed without clearing the Date/Time.

- Unchecked: Aging runs as normal.

**Aging Report Show Age Pat Payplan Payments**: If enabled, a checkbox will be added to the Custom Aging Report(1341) window to age patient payments to Payment Plans. Additional Payplan logic settings can be found in Account Module Preferences(693), Misc Account tab.

**Aging Service Time Due**: Time of day aging will be calculated. Aging will run during a block of time starting at the time set.

**Patient Payments Use**: Determines the default clinic for patient payments (Payment(153) window). There are three options.

- **SelectedClinic**: Use the clinic selected in the main menu under Clinics.
- **PatientDefaultClinic**: Use the patient's default clinic as set on the Edit Patient Information(62). If the patient's clinic is Unassigned, the default clinic will be none.
- **SelectedExceptHQ**: Use the clinic selected in the main menu, unless it is Headquarters. In that case, use the patient's clinic.

**Payments prompt for Payment Type**: Determines whether or not a payment type is automatically selected when entering a patient payment.

- Checked: Users must manually select the payment type when entering a payment (no default selected).
- Unchecked (default): The first payment type in the list will be selected by default.

**Auto-split payments preferring**

- **Adjustments** (default): Open Dental will automatically suggest pay splits allocated to the oldest positive adjustment, then follow FIFO (First In First Out) accounting logic for the remaining outstanding charges.
- **FIFO**: Open Dental will automatically suggest pay splits allocated to the oldest, completed procedures without standing charges.

**Show all transactions since zero balance**: Check to include all transactions since the last zero balance for statements generated from Billing(504).

**Claim Identification Prefix**: Change the default format of the claim ID. This number is assigned to a claim using the prefix selected, then adding an auto-generated claim number. Useful for internal tracking of claims. Click Replacements to select a prefix.

**Receive Reports by Service**: Determines the method used to receive clearinghouse reports.

- Unchecked: The computer specified will receive the reports. This is the original method used by Open Dental.
- Checked: Receive reports using the OpenDentalService (see Service Manager(1412)). This method is recommended for remote app users.

**Receive at an Interval**: Set a time interval, in minutes, to automatically check the clearinghouse server and download new reports. Only values between 5 and 60 are allowed. 30 is the default.
Receive at a set time: Set a specific time to check the clearinghouse server and download new reports. Time will auto correct itself to valid format (e.g. 1:00 AM)

Enforce Valid Paysplits: Determines whether or not users are forced to allocate patient payments to procedures and unearned income. See Payment Preferences for more details.
- Enforce Fully: Open Dental will automatically suggest payment splits (paysplits) allocated to procedures, procedure treating provider, default clinic, and default unearned income types. Users can modify suggested paysplits, but are required to allocate to procedures or unearned income types. Credits on Payment Plans are also required to be attached to procedures.
- Auto-Split Only (default): Open Dental will automatically suggest paysplits allocated to procedures, procedure treating provider, default clinic, and default unearned income types, but user can modify splits or choose to remove allocations to procedures or unearned income types.
- Don't Enforce (old behavior): Open Dental will only suggest paysplits allocated to the procedure's treating provider. Users are not required to allocate to procedures or unearned income types.

Enforce Valid Adjustments: Determines whether clinic and provider of adjustments match clinic and provider of attached procedures. Also determines whether attaching adjustments to procedures is required or optional. Setting will only apply when adding new adjustments or editing existing adjustments.
- Enforce Fully: Attaching procedures to adjustments is required. Clinic and provider assigned will be the same as procedure. Users with the Setup security permission may edit the adjustment to assign a different clinic and provider than the attached procedure.
- Link Only: Clinic and provider assigned will be the same as procedure. Users may edit the adjustment to assign a different clinic and provider than the attached procedure.
- Don't Enforce: The patient's default clinic and provider will be assigned to the adjustment. Users may edit the adjustment to assign to the same clinic and provider as the procedure.

Note: Attaching adjustments through the Procedure Edit Window will always assign the procedure clinic and provider to the adjustment.

Hide paysplits from payment window by default:
- Checked: Current Payment Splits and Outstanding Charges will be hidden by default when the Payment window is opened.
- Unchecked: Current Payment Splits and Outstanding Charges will show by default when the Payment window is opened.

Pay Plan Charge Logic: Determines how charges and credits for Patient Payment Plans show in the patient account ledger and whether they affect balances, aging, and reports.
- Do Not Age (Legacy): Payment plan debits (amounts due) and payments only show within the payment plan and will not affect balance or aging.
  - Payment plan debits are totaled in the Payment Plans grid under Due Now.
  - Payment plan payments do not show in the ledger but in the payment plan. Double-clicking the plan row is the only way to view payment plan payments.
  - One payment plan credit (PayPln) will show as a single line item in the patient account ledger, thus reducing the total account balance by the amount. The credit amount is based on the Tx Completed Amt set in the payment plan.
  - Other payment plan credits, debits, and payments do not show in the ledger nor do they affect balances or aging.
  - The total A/R in the Aging of A/R report will not include payment plan due amounts.
  - Only changes to the Tx Completed Amount affect aging and production and income reports.
  - Payment plan amounts are not included on the Receivables Breakdown Report.
- Age Credits and Debits (Default): Payment plan debits, credits, and payments will show as line items in patient account ledger and affect balances and aging.
  - Payment plan amounts due (PayPln: Debit) and credits (PayPln: Credit) show as line items in the patient account ledger.
  - Payment plan payments show in the account ledger.
  - Payment plan due amounts are included the patient's balance.
  - Payment plan amounts due and payments are considered when calculating aging.
  - Payment plan credits and debits are included on the Receivables Breakdown report.
  - Changes made to historical payment plan charges will affect historical information (e.g. Aging of A/R, Production and Income reports).
• Age Credits Only: Patients are credited for payment plans when the credit comes due, but debits all exist separately from the account ledger.
  o Each payment plan credit line item will show in the account ledger, sorted by Tx Credit date.
  o Payment plan debits only show in the Payment Plan grid. They do not show in the account ledger.
  o Payment plan amounts due will not be considered when calculating balances and aging.
  o Payment plan credits and debits will not be included on the Receivables Breakdown report.
  o Changes made to historical payment plan credits will affect historical information (e.g. Aging of A/R, Production and Income reports).
• No Charges to Account (Rarely Used):
  o Payment plans have no affect on account balance.
  o Payments to payment plans show in ledger and payment plan.
  o Payment plan amount is not removed from aging.
  o Payment plan amounts will not be included on the Receivables Breakdown report.

Max number of statements per batch (0 for no limit): Enter the maximum number of statements that will be considered a batch when sending statements via the Billing List. Enter 0 to set no limit. Useful for large offices that send many statements.

Show progress when sending statements: Determines whether or not a progress bar shows when sending statements via the Billing List.
  • Checked: A progress bar does show that includes options for pause, resume, cancel.
  • Unchecked: A progress bar will not show.

Advanced Tab
Passwords must be strong:
- Checked: All passwords must be at least 8 characters and contain at least one number, one uppercase letter, and one lowercase letter.
  - Note: If using Mobile Web and passwords are changed to must be strong, users who do not have a strong password must change passwords to meet the criteria before they can access the Mobile Web. Users who already have a strong password do not need to go through this process.
  - When passwords must be strong, a password is required when adding a new user.
- Unchecked. Strong passwords are not required.

Strong passwords require special character:
- Checked: When passwords must be strong, the password must also contain at least one special character (e.g. #, $, !).
- Unchecked: A special character is not required.
**Force password change if not strong:**
- Checked: When passwords must be strong, users who do not have a strong password will be required to change their password the next time they log on so it meets criteria.
- Unchecked: Users will not be required or prompted to change to a strong password.

**Lock includes administrators:** Lock limitation applies to Admin user group. See [Security Lock Dates](#) (1122).

**Automatic logoff time in minutes (0 to disable):** Set the number of minutes before idle users are automatically logged off. Setting "0" will disable this function.

**Manually enter log on credentials:** When checked users will have to type their username and password to log on. If unchecked username can be selected from the list.

**Global Lock:** Global lock dates prevent editing of old items and are the only way to prevent backdating of new items.
- Lock Date: Changes will only be allowed if they occur before the date entered.
- Lock Days: Changes will only be allowed within a set amount of days from the original entry date.
- Change:

**DBM Disable Optimize:**
- Checked: The Optimize Database tool will be disabled. See [Database Maintenance](#) (1434)
- Unchecked: The Optimize Database tool will be available.

**DBM Skip Check Table:**
- Checked: Database Maintenance will skip table checks.
- Unchecked: Database Maintenance will check table integrity.

**Clinics (multiple office locations):** See [Clinics](#) (1505). Must be enabled from [Show Features](#) (806).

**Disable signal interval after this many minutes of user inactivity:** This setting is only valid if you have entered a value for Process Signal Interval below. Enter the minutes of workstation activity that will cause Open Dental to stop sending automatic signals to refresh information. We recommend setting a value similar to the value of any auto log off options for Open Dental or Windows (see [Global Security Settings](#) (1107)). Disabling the signal during workstation inactivity can prevent errors due to lack of network access (e.g. the server is down). Once the workstation becomes active (e.g. with a mouse click or mouse movement), the signal will resume at the set intervals (see above). Leave the field blank if you do not want to disable the signal during periods of inactivity.

**Process signal interval in seconds. Usually every 6 to 20 seconds:** The interval, in seconds, that Open Dental will automatically refresh the Appointments module, task lists, and text notifications. Usually the value will be 6 to 20 seconds. Leave the field blank to disable auto-refresh. See [Refreshing Data](#).
- Note: If a workstation has a network access issue when it sends a signal, you will receive an Unhandled Exception error. We recommend clicking Quit, then restarting Open Dental.
- A value must be entered when using the [Kiosk Manager](#) (1444) feature.

**Patient Select:**
- The number of characters entered into the search fields before filling the grid: Reduces server load when [Selecting a Patient](#) (1649) by not requesting results until specified number of characters have been entered. One to ten characters, try starting with 3.
- The number of milliseconds to wait after a character is entered before filling the grid: Reduces server load when selecting patients by adding a delay before requesting search results as user types. One to 10,000 milliseconds, try starting with 1500.
- Search and fill grid with all empty search fields: By default, opening Select Patient window will populate the grid before any search fields have been entered. Uncheck to reduce server load by requiring user to click Search before populating the grid if no search terms have been entered.

**Appts Tab**
Appointments require procedures: Determines whether or not new appointments must have procedures attached.
- Checked: At least one procedure must be attached to an appointment before it can be created.
- Unchecked: Appointments can be created with no procedures attached.

Force op's hygiene provider as secondary provider: Determines the default hygienist when scheduling an appointment in an operatory.
- Checked: The hygienist of the operatory is always assigned as the hygienist on the appointment, even if none.
- Unchecked: The hygienist of the operatory is assigned as the hygienist unless it is none. In that case, the patient's secondary provider is assigned.

Enterprise Appointment Lists: Preference to reduce unnecessary server traffic.
- Checked: Many forms will not automatically load information while Headquarters is active Clinic. All option will not be available in Clinic selection boxes. Reduces server load.
- Unchecked: Information will continue to load normally when Headquarters is active clinic. All option will be available in Clinic selection boxes. May reduce performance of Open Dental.

**Do not default to 'None' Appointment View when other views are available:**
- Checked: Disable default Appointment View(7) of None in the appointment module.
- Unchecked: If no appointment view is selected for a user, the None view will be used by default.

### Family Tab

#### Super Families: Turn on Super Family(143) features.

#### Patient Clone: Turn on Patient Clones(145). Useful for orthodontist offices who want to track production and income separately.

#### New patient clones use superfamily instead of regular family:
- Checked: New clones will be created as the guarantor in their own family. If no Super Family exists, one will be created to include original patient and clone patient. If original patient is already part of a Super Family, clone will join existing Super Family. See Super Family(143).
- Unchecked: New clones will inherit guarantor and Super Family settings from original patient.

#### Claim Snapshot Enabled: If checked, snapshots of claim procedures are created when a claim is created.

#### Snapshot Trigger: Only visible if Claim Snapshot Enabled is checked. Determines when a Claim Snapshot is created.
- Claim Created: By default the snapshot is created at the time the claim is created.
- Service - Specific Time: Snapshots will be generated by a service at the Service Run Time set below.
- Insurance Payment Received: Snapshot will be created when the Insurance payment it received.

#### Service Run Time: Only visible if Claim Snapshot Enabled is checked. Determines time of day OpenDentalService should create Claim Snapshot.

### Reports Tab
Use separate reporting server: A report server can be useful to large offices to prevent lockups and slowness in a live database. See Report Server (1094).

**Direct Connection**
- **Server Name**: The name of the computer acting as the report server.
- **Database**: The database to connect to.
- **MySQL User**: Default user is root. See MySQL Security.
- **MySQL Password**: The user password (if you have set up MySQL users and password).

**Middle Tier**:
- If you do not know your URI, see Middle Tier Troubleshooting for help.
Fee Schedules

In the Main Menu(592), click Setup, Fee Schedules.

Alternatively:
- In the Chart Module(298), in the Enter Treatment(301) tab, click Procedure List. Click Fee Scheds.
- In Procedure Codes(1195), at the bottom right, click Fee Scheds.

Typically you will create a fee schedule for your Usual Customary and Reasonable (UCR) fees and for each insurance company you are contracted with. A fee schedule can allow a single (global) fee per procedure, or allow provider and/or clinic-specific fees. For an explanation of how a patient's fee schedule is determined, see Fee Schedule Logic(1209). Users must have the Edit Fee Schedule permission to access the Fee Schedule window.

Also see Procedure Codes(1195) for information on entering fees and editing procedure codes.

See Fee Tools(1210) for information on copying fee schedules and editing fees.
To print a fee schedule, see Procedure Codes - Fee Schedules Report (1361).

**Create a Fee Schedule**

1. Open the Fee Schedules window. Fee schedules that already exist are listed. To only show fee schedules of a certain type, select the Type in the upper right. The sort order here determines the sort order when selecting a fee schedule throughout the program.
   - **Up/Down**: Reorder the fee schedules. Select a fee schedule, then click Up or Down to move it.
   - **Sort**: Quickly sort the fee schedule list alphabetically by type (Normal first, then CoPay, then Out of Network).

2. Click Add or double-click an existing fee schedule to edit.

   ![Edit Fee Schedule Window](image)

   3. **Description**: Enter the name of the fee schedule.

   4. Select the type. This property cannot be changed once the fee schedule is created. See Insurance Plan Types (114) for more examples of when to use each type.
      - **Normal** = In network fee schedules. These types of fees schedules are options in the Fee Schedule dropdown on the Insurance Plan (81).
      - **Copay** = A set fee schedule the patient is responsible for per procedure. Copay fee schedules can work in conjunction with percentage-based plans. To determine how blank entries in a copay fee schedule are treated, see Co-pay fee schedules treat blank entries as zero in the Family Module preferences (637).
      - **Out of Network** (formerly called Allowed) = A fee schedule for fees allowed by insurance, even if you are not contractually obliged to follow them. These types of fee schedules are options for Carrier Allowed Amounts on the Edit Insurance Plan window. When computing estimates, all percentages will be based on this out of network amount instead of on the procedure fee. Blank amounts are ignored and will not change the estimates. But out of network amounts of zero will result in an estimate of zero. Out of network fee schedule entry can be automated using the Blue Book (918) feature.
      - **FixedBenefit** = A fee schedule from insurance where they pay a fixed amount for each procedure code. This fee schedule is an option for PPO Fixed Benefit Insurance Plan (117) only. To determine how blank entries in a fixed benefit fee schedule are treated, see Fixed benefit fee schedules treat blank entries as zero in the Family Module preferences.

   5. **Use Global Fees**: Set whether the fee schedule will only allow a single (global) fee per procedure, or allow provider and/or clinic-specific fees.
      - **Checked**: Only allow a single fee per procedure.
      - **Unchecked**: Allow provider and/or clinic specific fees per procedure. This box can only be changed when the logged-on user has the Provider Fee Edit permission and, if Clinics is turned on, Headquarters is selected in the main menu. See Fee Override for Provider or Clinic (1206) to enter fees.

5. Click OK to save.

A fee schedule cannot be deleted, but can be hidden as a selection option as long as it is not associated with a provider or patient. On the Edit Fee Schedule window, check Hidden.

**Clean Up Allowed**

This button is only visible to users with the Security Admin security permission. Use it to delete out of network fee schedules that are not being used or are attached to hidden insurance plans. It is sometimes useful if you have used the Blue Book (918) feature.
**Hide Unused**
This tool will allow you to mark any unused fee schedules as hidden.

Before you run the tool, you will be prompted to make a backup of the database. This may take a while.

Click OK. Any fee schedules not used by insurance plans, patients, providers, or discount plans will be hidden.

**Check Ins Plan Fee Schedules**
This tool allow you to check that insurance plans have the correct fee schedules or reassign fee schedules for multiple insurance plans at once. Click Go to make sure that insurance plans have the correct fee schedule attached. See [Check Ins Plan Fees](916).

**Check Ins Plan Fees**
In [Fee Schedules](914), at the bottom, click **Go**.
The Check Ins Plan Fees tool allows you to check that insurance plans have the correct fee schedules or reassign fee schedules for multiple insurance plans at once.

Enter filter criteria at the top to filter the list of insurance plans.

- Fee schedule type (normal, copay, out of network)
- Carrier Like: Enter carriers to include.
- Carrier Not Like: Enter carriers to exclude.
- With Fee Schedule: Select fee schedules to include.
- Without Fee Schedule: Select fee schedules to exclude.

Checking plans for the correct fee schedule: Example: If you have a special fee schedule that all Aetna plans should be on, type Aetna in the Carrier Like box. If the results include Aetna plans that do not have the Aetna fee schedule, there may be incorrect fee schedule assignments.

To also make sure no other plan was accidentally assigned an Aetna fee schedule, type Aetna in the Carrier Not Like box and select Aetna for With Fee Schedule. The list should be empty. If there is a result, a fee schedule was assigned incorrectly.

Change fee schedules for multiple plans at once:
1. Highlight the insurance plans to change fee schedules for.
2. Next to New Fee Schedule, select the new fee schedule to assign to the selected plans.
3. Click Change to permanently change all selected plans. A confirmation message will show. Click Yes.
4. To prevent accidental changes, you will be prompted for a password. It is fee. Click OK.

A message box will indicate how many plans were changed.

**Blue Book**

Open Dental has some capability to automatically track out of network (allowed) fee schedules. We call this feature Blue Book. In other software, this is also known as coverage tables or payment tables.

To turn on this automation, in **Family Module Preferences** (637) check **Use Blue Book**. This is what will happen:

- For each **Carrier** (1237) associated with an out of network (Category Percentage) plan type, an out of network fee schedule (named by carrier, Use Global Fees checked) is automatically created. There are no changes to PPO plans.
- The new out of network fee schedule is attached to the insurance plan in the Carrier Allowed Amounts dropdown. This fee schedule is used to track out of network fees.
- Enter out of network / allowed amounts in the **Procedure Codes** (1195), as you enter **Claim Payments** (231), or in the **Claim Procedures** (claimprocs) (221). Once entered, allowed/out of network fees are used for all estimates instead of the regular fee.

**Note:** Be careful when entering out of network fees. Make sure you enter the true allowed amount, not a fee reduced by deductible, etc.

To turn automatic generation of fee schedules off, uncheck the Use Blue Book box. The out of network fees will continue to update automatically, but fee schedules will need to be managed manually.

To clean up unused out of network fee schedules, see **Fee Schedules** (914).

Use the Blue Book feature sparingly until we can make improvements. Some of the problems identified are:

- It can make fee schedules hard to manage, especially if you have lots of plans that are automatically duplicated. Your fee schedule list can become very cluttered.
- Since the names are by carrier, we have had complaints that this is not fine-grained enough. Users would rather organize the allowed/out of network fee schedules at the plan level.

Our plan is to no longer show Blue Book fee schedules in the Fee Schedules window. We will instead build a new interface, accessible directly from the **Edit Insurance Plan** (124) window. The tool should let users see historical trends for each code and fine-tune what the future estimates should be for each code. This is feature request #2099.

**Laboratories**

In the **Main Menu** (592), click Setup, Laboratories.
The Laboratory list contains details about the laboratories you send Lab Cases (379) to.

Click **Add** or double-click on an existing lab to edit.
Enter lab details:
- Description: Name of laboratory.
- Phone: Contact phone number.
- Wireless Phone: Additional contact phone number.
- Address: Laboratory address.
- City / State / Zip: City, state, and zip code of laboratory.
- Email: Email address for laboratory.
- Notes: Any related notes for the laboratory.

**Is Hidden**: Check to hide laboratories no longer in use.

**Lab Slip**: Select the default lab slip sheet template to use for this lab. See Lab Slip Layout(1162) to customize a lab slip.

**Turnaround Times**: Enter turnaround times for services provided by the lab. Adding, editing, and deleting turnaround times affects due date calculations for future lab cases, not existing ones.

Click **Add**, or double-click a service to edit.
Enter the turnaround information:

- **Service Description**: The service offered by the lab.
- **Days Published**: The turnaround time published by the lab.
- **Actual Days**: Might be one or two days longer to account for travel time or padding time.

**Miscellaneous Setup**

In the [Main Menu](592), click Setup, Miscellaneous.
In Miscellaneous Setup, customize Open Dental's general settings.

**Main Window Title:** Set what information shows in the Main Window title bar.

- **Title Text:** The text that shows at the very top left of the main window. Changing this text is useful when you use multiple databases so you can easily identify which database you are currently using.
- **Show ID in title bar:** Select which information shows in the title bar of Open Dental.
  - None: Do not show additional information in title bar.
  - PatNum: Show patient name and number.
  - ChartNumber: Show patient name and chart number.
  - Birthdate: Show patient name and birthdate.
- **Show patient specialty in main title bar and account patient select:**
  - Checked: Shows patient specialty in title bar and patient select area of Account Module.
- Unchecked: Does not show patient specialty.
- **Show Site**: Show the patient's site if **Public Health** (71) is turned on ([Site List](1272)).
- **Use clinic abbreviation in main title bar** (clinics must be turned on): This setting determines what shows in the title bar for the selected clinic.
  - Checked: The title bar shows the clinic's abbreviation.
  - Unchecked: The title bar shows the clinic's full description.

**Theme**: Determines look of the Open Dental module icons.
- Standard: Uses old style of icons.
- Flat: Uses old style of icons.

**Users can set their own theme**: Allows theme to be selected at the user level by clicking File, User Settings.

**Time Cards use local time**: This setting affects all workstations. It is useful when the server is in a different time zone than the workstation.
- Checked: The **Time Clock** (582) will use the workstation's local time.
- Unchecked: The time clock will use the server time. This keeps all times consistent throughout the office and prevents tampering with the computer clock if the server is physically inaccessible.

**New Computers default to refresh while typing in Select Patient window**: Sets the default setting of the **Refresh while typing** checkbox on the Select Patient window for new workstation installations ([Select Patient](1649)).
- Checked: The default setting for the **Refresh while typing** checkbox will be checked when installing on a new workstation.
- Unchecked: The default setting for the **Refresh while typing** checkbox will be unchecked when installing on a new workstation.

**Search for preferred name in the first name field in Select Patient window**: Sets the search behavior of the First Name field on the Select Patient window.
- Checked: Open Dental will search for patients with matching first name or preferred name.
- Unchecked: Open Dental will search for patients with matching first name only.

**Process Signal Interval in seconds**: The interval, in seconds, that Open Dental will automatically refresh the Appointments module, task lists, and text notifications. Usually the value will be 6 to 20 seconds. Leave the field blank to disable auto-refresh. See [Refreshing Data].
- **Note**: If a workstation has a network access issue when it sends a signal, you will receive an Unhandled Exception error. We recommend clicking Quit, then restarting Open Dental.
- A value must be entered when using the **Kiosk Manager** (1444) feature.

**Disable signal interval after this many minutes of user inactivity**: This setting is only valid if you have entered a value for Process Signal Interval above. Enter the minutes of workstation activity that will cause Open Dental to stop sending automatic signals to refresh information. We recommend setting a value similar to the value of any auto log off options for Open Dental or Windows (see [Global Security Settings](1107)). Disabling the signal during workstation inactivity can prevent errors due to lack of network access (e.g. the server is down). Once the workstation becomes active (e.g. with a mouse click or mouse movement), the signal will resume at the set intervals (see above). Leave the field blank if you do not want to disable the signal during periods of inactivity.

**Languages used by patients**: Set up specific **Language** (925) which can then be assigned in the **Edit Patient Information** (62).

**Language and region used by program**: Shows the database's current language and region setting. To change the database setting, click [...].
Click the New Database Setting dropdown arrow and select the new language and region. Click OK to save.

Usually database and computer settings will match. If they don't, a warning will show every time Open Dental starts. To stop this warning from showing, check the 'Do not show this window on startup (this computer only)'. Change computer settings in the Control Panel, Region and Language.

**Currency number of digits after decimal**: Indicates the current computer setting for digits after the decimal for currency amounts. The recommended value is 2. If the value is anything different, the message below will show every time Open Dental starts.

To change the currency setting, go to the Control Panel, Region, Additional Settings, Currency tab. To stop this message from showing on startup, check 'Do not show this window on startup (this computer only)'.

**Text boxes use foreign language Input Method Editor (IME) composition**: Determines composition if you are typing in a foreign language that uses an IME keyboard (e.g. Korean, Arabic).
- Unchecked: Leave unchecked for standard english keyboards.

**Update Server Name**: For the Middle Tier, it identifies which computer is running the middle tier. It also indicates the one and only computer name that has permission to execute updates (e.g. via the Help, Update menu, via command line). This helps avoid unwanted updates when offices have multiple locations potentially running different versions of Open Dental.

**Track Last Clinic By**: For Clinics (1505) only. Affects which clinic is selected in the Main Menu, Clinics when a user logs on to a workstation.
- None: Select the user's default clinic.
- Workstation: Select the clinic last selected on the workstation, if the user has access to it. If not, select the user's default clinic.
- User: Select the clinic that was active the last time the user logged off.
Sync code for CEMT: Indicates the Sync Code of the Central Enterprise Management Tool (CEMT) database this database is associated to. All database connections which are affected by a CEMT sync have a code listed here. If you clear the code, you can sync from any database, but this is not recommended.

Number of Audit Trail entries displayed: Set the default number of log entries that will display in the Audit Trail (1424) at one time.

Automated aging run time, only applies if using Daily aging. Leave blank to disable: This option is useful to prevent aging from running during high use hours. Also recommended if the Account Module Preference, Recurring charges run automatically is enabled. Specify a certain time of day to automatically run daily aging after midnight (e.g. 1:00 am). The OpenDentalService must be installed and running during the aging run time. See Service Manager (1412).
- If you change the aging run time, restart the OpenDentalService.
- If this value is blank, aging will run based on default rules.

Aging for enterprise Galera cluster environments using FamAging table: Only used by enterprise organizations that use Galera cluster environments to prevent possible deadlocks when running Aging (1423).
- Checked: A password is required to check this box; it is abracadabra. When checked, aging will only calculate once per day and a second field labeled DateTime the currently running aging started will show.

If aging is running, the date and time it started will appear and clear once aging is completed. As long as there is a value in the field, another person cannot run aging simultaneously (thus preventing possible deadlock). To clear the value (e.g. to allow another person to run aging), press Clear. This is rare and typically only done if aging started on a computer that was forcefully closed without clearing the Date/Time.
- Unchecked: Aging runs as normal.

Automatically submit unhandled exceptions: Determines if Unhandled Exception errors are sent to Open Dental headquarters.
- Checked: Automatically submit Unhandled Exception errors to Open Dental Headquarters. This is done in the background securely and no PHI is sent. Errors are only sent for offices on the latest stable version or using any beta version.
- Unchecked: Disables automatic submission of Unhandled Exceptions.

Middle tier server caches all fees: Determines if a Middle Tier server will cache non-hidden fees. Useful for offices experiencing slowness. Only applicable if using Middle Tier.
- Checked: The Middle Tier server will store non-hidden fees for all clinics in its cache. When checked, restart the Middle Tier server’s IIS for changes to take affect.
- Unchecked: The Middle Tier server will use the database to find a fee.

For global and local computer settings for tasks, see Tasks Preferences (1192).

Language
In the Edit Patient Information (62) window, select the Language dropdown.
To add languages to the dropdown menu, edit the Language Definitions.

In the **Main Menu** (592), click Setup, **Miscellaneous** (921), then Edit Languages.

![Language Definitions](image)

- **All Languages**: Microsoft-supported languages.
- **Custom**: Add custom language options.
- **Languages used by patients**: The language options that show in the Language dropdown on the Patient Edit window, listed in the order they appear.
- **Indicator that patient has no specified language**: For EHR (see [Open Dental EHR](#)). This language is the indicator that patient declined to specify a language. Only Custom options can be selected. This indicator is recognized in [EHR Measure Reports](#) (434) as acceptable input.

Add languages to the list of Languages used by patients. They can only be added one at a time.
- Highlight a language, then click **Add**.
- To add a language not in the list, enter it in the Custom text field, then click **Add**.
EHR Users: Specify the indicator when a patient does not specify a language.
- Create a custom language and add it to the list of Languages used by patient (e.g. Declined to Specify).
- If there is only one custom option, it will be selected by default. Otherwise click the dropdown to select the indicator.

To reorder the list, highlight a language, then click the up/down arrows to move it.

Click OK to save.

Module Preferences
In the Main Menu, click Setup, Module Preferences.

Click one of the tabs.
- Appointments Module Preferences
- Family Module Preferences
- Account Module Preferences
- Treatment Plan Module Preferences
- Chart Module Preferences
- Images Module Preferences
- Manage Module Preferences

Ortho Setup
In the Main Menu, click Setup, Ortho.
The preferences below affect options used for Orthodontics(929). Check a feature to turn it on; uncheck it to turn it off.

**Show ortho case in account module:**  
- Checked: Show Ortho Case(275) in the Account module and in the Insurance Plan(81) (Ortho Case tab).  
- Unchecked: Don't show the Ortho Case tab.

**Show ortho case information in the ortho chart:**  
- Checked: Show patient ortho info from the Ortho Case tab (PatOrthoInfo) in the upper right of the Ortho Chart(390).  
- Unchecked: Don't show ortho case information in the ortho chart.

**Mark claims as Ortho if they have ortho procedures:**  
- Checked: Automatically mark the Is Ortho box on the Edit Claim - General Tab(213) when creating a claim or preauthorization that includes an orthodontic procedure (within the orthodontic insurance category span).  
- Unchecked: Don't automatically mark the box.

**Use the first ortho procedure date as Date of Placement:**  
- Checked: Automatically insert the date of the initial orthodontic procedure (Date Start on the Ortho Case tab) as the Date of Placement on the Edit Claim - General tab when creating a claim that includes an orthodontic procedure (within the orthodontic insurance category span).  
- Unchecked: Don't automatically insert the date.

**Default months treatment:** Set a default total treatment amount, in months, that shows on the Ortho Case tab (Tx Months Total). If a patient's insurance plan is set to an ortho claim type of Initial Plus Periodic (Edit Insurance Plan - Ortho tab), this amount is used to determine the end date for generating periodic orthodontic claims using Ortho Auto Claims(1425).
Show Ortho Chart in appointment options:
- Checked: Show a Go To Ortho Chart option when user right clicks on an appointment box. This box is checked by default if data exists in the Ortho Chart. Customize the text in Ortho Chart Setup(392).
- Unchecked: Do not show a Go to Ortho Chart option.

Patient Clone:
- Checked: Turn on Clone(145) options.
- Unchecked: Turn off Patient Clones options.

Default Ortho Auto Proc: If using the Auto Ortho Tool to generate claims, set the default procedure code that will be used on the claim and sent to insurance. The default it is D8670.auto, but you can select any procedure code. Click [...] to change.

Note: Only the first 5 digits of procedure codes are sent to insurance. The .auto portion of the procedure code is not sent to insurance. So while D8670.auto will show on the Edit Claim window, only D8670 is sent to insurance. Using a procedure code with .auto is optional, but doing so is useful to track codes used on auto-generated claims.

Consolidate Ortho Insurance Payments:
- Checked: Block users from entering payments on claims created using the Auto Ortho Tool. If they attempt to do so, they will receive a message directing them to instead enter the payment as a supplemental payment on the initial procedure's claim (consolidating the payments).
- Unchecked: Allow users to enter payments on claims created using the Auto Ortho Tool.

Ortho Chart Display Fields: Click Edit to define the tabs and columns that show in the Ortho Chart. See Ortho Chart Setup.

Ortho Placement Procedures: Define which procedures can be considered as the initial orthodontic procedure. The initial procedure determines the default Date Start on the Ortho Case tab and can optionally determine the default Date of Placement on the claim (see Use the first ortho procedure date as the Date of Placement above). If no procedures are defined, Open Dental will attempt to use the first procedure within the code span D8000-D8999 as the initial orthodontic procedure.

To add a procedure to the list of initial orthodontic procedure options:
1. Click Add.
2. Select a procedure from the Procedure Codes(1195).
3. Click OK.

To remove a procedure, highlight it then click Delete.

Orthodontics
Open Dental is customizable for orthodontic specialty practices. We continue to refine and expand features for this specialty.

Webinar: Orthodontic Features in Open Dental

General Setup
Chart Module Preferences(706): Set the tooth nomenclature to Palmer.
Ortho Setup(927): Set default orthodontic preferences for display options, claims, and the ortho chart.
Ortho Chart Setup(392): Create tabs to organize ortho chart information and set which columns of information show on each tab.
Procedure Codes(1195): Add and edit procedure codes and set default procedure fees and time patterns. You will generally have two types of procedure codes.

- Procedure codes for charging fees/billing insurance (typically standard ADA codes). Add suffixes to the ADA codes to differentiate multiple fees for the same procedure. Only the first 5 digits of the code are sent in claims; extra letters are dropped when billing.
- Procedure codes for scheduling patients (N codes). These procedures would not be billed to insurance. For example, N0001 could be Take records, and N0002 could be Cement bands. See Add Procedure Code(1204). When creating an N code, check do not bill to insurance.

Patient Management
Clone(145) creates a clone of the original patient (in ALL CAPS). Specific demographic information and insurance plan data can be synced from original to clone patient. Offices that offer general dentistry and orthodontics use patient clones to keep accounting separate. For example, track production and income for each provider that treats the same patient, such as dentist versus orthodontist work.

Scheduling
Add the procedure(s) to the appointment, assign your provider, then schedule it. See Edit Appointment(20).

Appointment schedule: To quickly identify appointment providers or type by color, there are a few options:
- If patients are typically scheduled with specific assistants, consider adding your assistants as secondary providers and assign them to the appointments. Use appointment color to quickly see which assistant is assigned to each appointment.
- To quickly identify orthodontic procedures by appointment color, create one orthodontic provider to assign to orthodontic appointments (e.g. Orthodontist).
- Set up different Appointment Types(619) (e.g. ortho, initial impression, wire change) and assign to each appointment.

Hints:
- To manage future appointments, use Planned Appointments(325). Use the Planned Appointment Tracker to ensure planned appointments don't slip through the cracks.
- Ensure time patterns for initial procedure codes are accurate so that each appointment reflects correct provider time (X = provider time).
- Book multiple patients simultaneously with no restriction or limit on overbooking appointments. This makes it easy to move patients to the best times. Try to schedule the patients so that the provider time stays fairly constant, even if it sometimes gets double booked.

Charting
Enter procedures in the Chart module and organize them in Treatment Plans.
- Ortho Chart(390): Keep track of visits.
- You can change any fee for any procedure after adding it to the patient's chart.
- Exam Sheets can replace any paper exam forms. See Exam Sheet(397).
- Customize treatment priority names to sequence treatment as needed. See Definitions: Treat' Plan Priorities(893).

Insurance and Billing
- Enter an insurance plan’s orthodontic lifetime max and percentage on the Edit Benefits window.
- Define the insurance plan’s orthodontic claim preferences from the Insurance Plan(81) - Ortho tab.
- Quickly view a patient's orthodontic case information in the Account module, Ortho Case tab or in the Ortho Chart.
- Add procedures for billing purposes only using Quick Procs or by simply setting a procedure complete.
- Payment Plan(239): Set up an unlimited amount of payment plans per patient. The guarantor does not have to be in the same family as the patient. You have total control over the date, principal, and interest of every single payment on the amortization schedule.
- Auto Ortho Tool(1425): When a plan requires that you submit an initial claim, then submit periodic claims at a certain frequency and fee, you can use Auto Ortho Claim Generation to quickly generate periodic claims.

Miscellaneous
Referrals(76): Track and report on referrals to see at a glance who referred each patient to your office. You can merge letters for your referral sources as well.

Patient Letters: Letter(1678) to create school excuse slips or other patient communication.

Practice Setup
In the MainMenu(592), click Setup, Practice.

Practice information includes general contact information, billing and pay-to addresses, and default providers.

Note: Practices that have multiple locations should use the Clinics(1505) feature and assign each patient to the appropriate clinic.

Enter practice details:

Practice is Medical: Enable the non-dental interface. See Non-Dental(932).

Provider Name/Practice Title: If there is only one provider, the practice title can be the name of the provider. For the logic that determines which address is used in printed and electronic claims, see Claim Addresses(223).

Physical Treating Address: The physical location where treatment is performed. This address is always used on statements.
**Billing Address**: Only needed if different than Physical Treating Address. Must be a physical address (not a PO Box). Check **Use on Claims** to use in both printed claims and e-claims. For **Electronic Billing** statements sent to DentalXChange, it will override the practice address.

**Pay To Address**: Only needed if different than Physical Treating Address. The address where the insurance payment will go. It can be a PO Box. Sent with the billing address in 5010 e-claims and, if entered, will override the billing address on printed claims.

Note: 5010 e-claims require a 9 digit zip code (see [https://tools.usps.com/go/ZipLookupAction_input](https://tools.usps.com/go/ZipLookupAction_input)).

**Bank Deposit Acct Number and Info**: The bank account that deposits will be made to. This account number will be used on daily **Deposit Slip**.

**Default Provider**: The default provider to assign to new patients. Also used to determine the standard fee schedule.

**Default Billing Type**: The default billing type for this practice. Customize options in **Definitions: Billing Types**.

**Default Proc Place Service**: The default place of service assigned to new procedures (Procedures-Misc Tab) and when completing procedures. This option is only visible if **Public Health** is turned on.

**Default Insurance Billing Provider**: The default billing provider on claims. This does not affect treating provider.

**Default Practice Provider**: The default provider selected above.

**Treating Provider**: The treating provider. See **Claim**. Treating Provider for logic that determines who the treating dentist is.

**Specific Provider**: A specific provider.

Note: If using clinics, clinic addresses may override practice addresses on claims.

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**Non-Dental**

For practices or clinics using Open Dental for non-dental purposes, you can change the Open Dental interface to remove dental information.

In the **Main Menu**, click Setup, **Practice**, then check the **Practice is Medical** box.
If using clinics: In the main menu, click Lists, Clinics (1505), then check the Clinic is Medical box.

Enable the Non-Dental Interface
When Practice is Medical is enabled, the following changes occur will occur:

- Throughout the software, most references to teeth and surfaces are hidden.
- The Chart and Treatment Plan icons will be non-dental.
- In the Chart Module (298):
  - The graphical tooth chart is hidden and the note box is larger.
  - Tabs for Missing Teeth, Movements and Primary no longer show.
  - Buttons for Perio Chart, Tooth Chart and Ortho Chart are removed from the toolbar.
- The Edit Benefit Window displays in Row View only (Edit Benefits - Row View (91)).
- In Reports, the Procedure Code column is widened to accommodate up to 15 characters.

Below is an example of the non-dental interface in the Chart module.

Other Useful Features
Other possible interface changes:

- In the Chart module, Show Chart Views (328), create customized views for the Progress Notes by removing columns that pertain to dental.
- Customize definition options by renaming, editing, or removing dental options and adding others (Appt Procs Quick Add, Proc Button Categories, Diagnosis, Image categories, Proc Code Categories, Provider Specialties), Definitions (835)
- In Display Fields (900), remove dental columns from the interface (e.g. ProcedureGroupNote, TreatmentPlanModule).
Other features useful for non-dental practices:

- Set a default start / stop range for patient medications in the Chart Module Preferences(706).
- Enter medical lab orders. EHR Medical Lab Order (CPOE)(403)
- Import or enter lab results. EHR Lab Results(404)
- Add custom patient information fields (e.g. primary care physician). Patient Fields(687)

Program Links
In the Main Menu(592), click Setup, Program Links.
The Program Links window lists all the Program Bridges you can link to from Open Dental. From here you can enable/disable a bridge, set up clickable toolbar buttons to access the bridge, and enter other bridge-specific information. For specific setup steps for each bridge, refer to the individual bridge page.

All supported bridges will list:
- Bridges marked X and highlighted green are currently enabled.
- If you do not see a bridge, you may be able to set up a custom bridge. See Custom Bridges(938).

Double-click a bridge to enter bridge settings on the Program Link window.
Each bridge window will auto-populate with default settings.

**Internal Name**: The internal name of the bridge.

**Description**: The name of the bridge as it shows in the list of program links.

**Enabled**: Check to enable the bridge. Uncheck to disable the bridge.

**Hide unused button**: This option only shows for bridges that have clickable buttons in Open Dental, if the bridge is disabled (Enabled is unchecked). Check the box to hide the button in the software (e.g. on the Reports(1276) window, Backup(541) window).

**Path of file to open**: The path to the program's executable (exe) on your computer or network. It can be a local path or a server path. This path will be used by all computers connected to the database, unless you enter a local path override on an individual machine.

Note: If the path is inaccurate, and Open Dental cannot find the exe file, then the program bridge will not work.

**Local Path Override**: On an individual machine you can enter a path to a program's executable (exe) that will override the Path of file to open. This is usually left blank.

**Optional command line arguments**: If a program bridge requires a command line argument, it will be specified in the Notes area. Otherwise this is usually left blank.

**Text on Button**: The text that will appear on the toolbar button, if you select to display a button in a module.

**Plug-in dll name**: See Plug-In Framework.
**Add a button to these toolbars**: Highlight where you would like to display a clickable button or option to open the bridge. Press Ctrl while clicking to select more than one option.
- AccountModule: Account module (150) toolbar (second row).
- ApptModule: In the Appointments module (1), next to the Appointment List and Printer icons (above the calendar).
- ChartModule: Chart module (298) toolbar (second row).
- ImagesModule: Images module (480) toolbar (second row).
- FamilyModule: Family module (59) toolbar (second row).
- TreatmentPlanModule: Treatment Plan (283) module toolbar (second row).
- ClaimsSend: Does nothing.
- Main Toolbar: Main toolbar (592) in every module.
- ReportsMenu: The Reports dropdown menu.

**Button Image**: Import an image that will show on the button.

- Click Import to select an image file from your computer. The image must be 22x22 pixels.
- Click Clear to remove an image.

**Additional Properties**: Set additional property values. Property values can be edited only. To change a value, double-click on a row. Enter the Value, then click OK to close.

![Edit Program Property](image)

**Notes**: Bridge specific instructions.

**Output File**: Build your own output file (for example, txt or ini) to custom bridges.

**Remote Desktop Solutions**
If you have a server using terminal services that users remotely connect to, consider using the Remote Executer program by MQ Technologies (http://www.mqtechnologies.com/en/home). Remote Executer passes the command to launch the software to the local computer, instead of launching the program on the server computer.

- The Path of file to open should contain the path to Remote Executer.
- Enter the path of the program to launch (e.g. VistaDent.exe) in the Optional command line arguments field.

**Troubleshooting**
If a bridge to an imaging program is not behaving well, first start Open Dental by right clicking, Run as Administrator. The administrator privileges will then be inherited by the bridge program. If this works, you can set Open Dental to always run as admin:
1. Right click on the desktop shortcut, then select Properties.
2. Click Advanced.
3. Check the Run as administrator box then click OK.
Custom Bridges

Custom bridges may be added if we do not offer a bridge for a program.

In Program Links(934), click Add.

Adding a customer bridge is useful if you know how to write output files. See Program Link Output File.

For a list of current program bridges, see Interoperability with Other Software.

Examples for custom bridges:
- Create a bridge to launch Outlook with a path of outlook.exe or using the path to the executable. Add a button for Outlook to a toolbar, or add a command line arguments to the bridge (e.g. [PatNum]), then create a macro in Outlook that recognizes the command line argument and opens up the patient in your contact list.
- Create a bridge to launch Excel.
- Bridge to your own custom program, e.g. a web-based program that you use to build special customized treatment plan layouts. Your program could take the PatNum, use queries to load all the other necessary info, and function like an extension of Open Dental.
- Add a toolbar button or Reports menu option that launches a web browser and loads a URL (e.g. a reporting URL). See Add a URL below.

Note: Only add custom bridges for bridges we do not already support.

Bridge Settings:

**Internal Name:** Is left blank for custom bridges. For existing bridges this is the internal name used by Open Dental.

**Description:** Enter the name of the bridge. This name will show in the Program Links list.

**Enabled:** Check to enable the bridge.

**Path of file to open:** Enter the website URL to launch.

**Local path override. Usually left blank:** Enter a local path override if any.

**Optional command line arguments:** Enter any command line arguments.

**Text on button:** Enter the text to show in the Reports menu or on the toolbar button.

**Additional Properties:** Not used for custom bridges.

**Notes:** Enter any notes about your bridge.

**Output File:** Click to build an output file for your custom bridge. See Program Link Output File.

Button Settings:

**Hide Button for Clinics:** If using clinics, select which clinics the bridge applies to.

- Use the left and right arrows to move unneeded clinics to the Hidden column.
- Hidden clinics will not show the bridge button. Visible clinics will show the bridge button in the selected toolbars.
- When a clinic is hidden, you will see the message *Program Link button is not visible for some clinics.* in the Program Link window.

**Order Alphabetical:** Check to order clinics in alphabetical order.

**Add a button to these toolbars:** Select where to display the button throughout the Open Dental program.

**Button Image (22x22):** Select an image to include on the button.

Click **Clear** to remove the existing image. Click **Import** to select a new image.
Imaging Hardware and Software

See [Program Links](934).

Below is a list of companies that manufacture and sell imaging hardware and software. It is an independent resource that includes companies our customers have worked with. For a list of bridges to imaging software and specific setup information for each, see [Program Bridges](934). For a list of other third party vendors that work with Open Dental, see [Vendors - Supplemental Services and Products](934).

Companies are listed alphabetically.

**AirTechniques** - They make the ScanX which is a popular phosphor plate system. They include imaging software called Visix, which is a rebranded version of Tigerview, and DBSWin. As with the other phosphor plate systems, Gendex Denoptix, Soredex Digora, and Orex, the advantages are the price and sensor comfort. The price is especially appealing if you need panos. The disadvantages are the time involved and the fact that the phosphor plates can become scratched.

**Ajat** - Pano hardware that uses TWAIN drivers. Capture using [Image Module](484).

**Apex** - Sensors that use Apteryx software.

**Apteryx** - Their XrayVision software can support almost all sensors on the market. The hardware support is just outstanding, and the software is powerful. Apteryx is frequently rebranded under different names, including Lightyear, Cliniview, and Prof Suni. Apteryx used to recommend Suni sensors, but now offers Tuxedo.

**Camsight** - No longer in business. Known for their digital surgical scope. Manufacture a variety of dental equipment. CDMi and CDMx software.

**Carestream** - SoftDent and Practice Works software, various hardware. Formerly Trophy, Kodak, Onex. The bridge from Open Dental to Trophy (Kodak) is the simplest of all the bridges. All it does is specify to Trophy the name of the folder containing the images of the current patient. The sensors require the proprietary imaging program to work.

**DentalEye** - Imaging software from Sweden.

**Dentrix Image** - See Kavo. Dentrix (not Image) still seems to be owned by Henry Schein.

**Dentsply Sirona** - Schick sensors and Sidexis imaging software which does not support other sensors.

**Dent-X** - Previously known for their line of chemical x-ray developers. Manufactures Eva sensors and Prolmage image management.

**Dexis** - See Kavo.

**DXIS** - Hardware retrofits existing pano machines to be fully digital without phosphor plates. We bridge to their standalone imaging software. No longer in business.

**FloridaProbe** - Automated perio probing hardware. They have also recently added a full-featured perio software. We have a bridge that works well.

**GE** - Sigma sensors with Cliniview software. Cliniview is a rebranded version of Apteryx.

**Gendex** - See Kavo.

**Kavo** - Gendex, Dexis, and Dentrix Image brands.

**Midmark** - Variety of equipment, including ClearVision sensor and Progeny Imaging.

**MediaDent** - Might be out of business. Purchased by SuccessEHS which was then purchased by Greenway Health. Website disappeared. They started out in medical imaging, and then moved into dental imaging. They also released a practice management software to complement their imaging software. They used an open SQL database.

**Owandy** - A French company that makes various hardware and software. Software is QuickVision.

**PatientGallery** Imaging software. Was formerly known as ImageFx.

**Planmeca** - Based in Helsinki. Software is Dimaxis. They manufacture hardware for both panoramic and intraoral radiography.

**PreXion** - 3D CBCT

**Schick** - See Dentsply Sirona.

**SciCan** - SciCan is better known for autoclaves such as the Statim. They also make intraoral cameras and ImageFX software (now PatientGallery?), but no x-ray equipment.

**Sigma** - Rebrands Suni sensors as Bio-Ray, and uses Apteryx for imaging.

**Suni** - Mysteriously went out of business in 2019. Used to sell sensors wholesale, then retail. Their imaging software, Professor Suni (Dr. Suni), was Apteryx software with a different name.

**Televere** - Makes Tigerview software. They do not manufacture hardware. Their support is good.

**Vatech** (1001) - This imaging company is committed to providing the industry with innovative dental x-ray imaging solutions while maintaining a primary focus on ultimately enhancing the quality of patient care.

**VideoDental** - RSV sensors are imported and distributed exclusively by VideoDental, who also distribute hardware and software from a variety of other manufacturers.

**XDR** - This software was written by Dr. Douglas Yoon, an expert in dental radiography. Dr. Yoon was the programmer who created the now famous automatic caries detection algorithm. XDR tends to use single-click enhancements and does not include features like colorization which are clinically useless. Good support.

**Sensors**

Open Dental works with all known sensors through direct bridging to all known dental imaging software (when the software company is willing and able to provide bridging instructions to our engineers). We do not recommend any specific brand of sensor or software. If you would like to share a particularly good or bad customer experiences, let us know and we may include it in our documentation.

In general the three major concerns when making a purchasing decision are:

- Total cost of imaging hardware, software, and support/training combined
- Clinical usefulness of the system (image quality and usage experience)
- Warranty (can you return it if you do not like it or it breaks?)

**Intraoral Cameras**

We do not directly support any intraoral cameras because we would have to support live video. If software came with your intraoral camera, you should use that. You could also purchase a third party imaging software such as one of those listed above that we have a bridge to.

To take still pictures with your intraoral camera, you might explore using a twain driver. Our software can accept still images coming in from twain devices, and some of our customers have been able to make use of this to capture still images. Images can only be saved one at a time.

**Acteon Bridge**

In the **Main Menu** (592), click Setup, **Program Links** (934). Double-click on **AIS from www.acteongroup.com/**.
Acteon is digital imaging technology. Website: https://www.acteongroup.com/en/.

To enable the bridge:
1. Check the Enabled box.
2. Verify the Path of file to open.
3. Double-click on Additional Properties to change settings.
   1. You can use the PatNum (enter 0) or ChartNum (enter 1) as the patient ID.
   2. Enter birthdate format.
4. Setup up a clickable bridge button.
   1. Under Add a button to these toolbars, highlight where to display the button.
   2. Enter the Text on button.
   3. (Optional) Import an image to show on the button (22 x 22 pixels).
5. If using clinics, click Hide Button for Clinics. Select which clinics the button should display on.
6. Click OK.

ADSTRA Bridge
In the Main Menu(592), click Setup, Program Links(934). Double-click on ADSTRA Imaging from http://adstra.com/adstra-dental-software/.
ADSTRA is digital imaging technology. Website: http://adstra.com/modules/adstra-imaging/.

To activate the bridge:
1. Check the Enabled box.
2. Verify the Path of file to open.
3. Double-click on Additional Properties to change settings. You can use the PatNum (enter 0) or ChartNum (enter 1) as the patient ID.
4. Setup up a clickable bridge button.
   1. Under Add a button to these toolbars, highlight where to display the button.
   2. Enter the Text on button.
   3. (Optional) Import an image to show on the button (22 x 22 pixels).
4. If using clinics, click Hide Button for Clinics. Select which clinics the button should display on.
5. Click OK.

**Technical Details**
Open Dental will send the selected patients last name, first name, date of birth and patient number or chart number to ADSTRA. If the patient does not exist in ADSTRA a new profile will be created.

**Apixia Bridge**
In the **Main Menu** (592), click Setup, **Program Links** (934). Double-click on **Apixia Digital Imaging by Apixia Inc.**

Apixia is digital imaging software. Website: [http://www.apixia.net/html/front/bin/home.phtml](http://www.apixia.net/html/front/bin/home.phtml).

To enable the bridge:
1. Check the **Enabled** box.
2. Verify the **Path of file to open**.
3. Double-click on a row in **Additional Properties to change settings**.
   1. Verify the **System path to Apixia Digital Imaging ini file** value. The `Switch.ini` must be in the same folder as the `digirex.exe` executable.
   2. You can use the PatNum (enter 0) or ChartNum (enter 1) as the patient ID.
3. Set up a clickable bridge button.
   1. Under **Add a button to these toolbars**, highlight where to display the button.
   2. Enter the **Text on button**.
   3. (Optional) Import an image to show on the button (22 x 22 pixels).
4. If using clinics, click **Hide Button for Clinics**. Select which clinics the button should display on.
5. Click OK.

**Technical Data**

Apixia uses a `Switch.ini` file to identify selected patients. Open Dental sends the selected patients birthdate, chart number (if selected), dentist ID (Open Dental provider abbreviation), digirex password (digirex), gender, name, and patient number to the `Switch.ini` file. The Apixia application loads the patient in the `Switch.ini` file.

Example File:
Apixia requires user IDs and passwords (these are not the Open Dental usernames and passwords). Use the DigirexServer application to add users for Apixia. The Dr.ID must match the provider abbreviation in Open Dental and all passwords must be digirex. If the user ID and password are not setup correctly, you will receive a message and Apixia will freeze.
Apteryx Bridge

In the **Main Menu** (592), click Setup, **Program Links** (934). Double-click on **Apteryx from www.apteryxware.com**.


This bridge is also used for: This table has been omitted.

To enable the bridge:

1. Check the **Enabled** box.
2. Verify the **Path of file to open**.
3. Double-click on **Additional Properties** to change settings. You can use the PatNum (enter 0) or ChartNum (enter 1) as the patient ID.
4. Set up a clickable bridge button.
   1. Under **Add a button to these toolbars**, highlight where to display the button.
   2. Enter the **Text on button**.
   3. (Optional) Import an image to show on the button (22 x 22 pixels).
5. If using clinics, click **Hide Button for Clinics**. Select which clinics the button should display on.
6. Click OK.
**Set up a Second Ateryx Bridge**

If using two imaging databases with Ateryx, you will need to set up two bridges.

To enable a 2nd bridge:
1. In the Main Menu click Setup, Program Links. Click Add to create a new bridge.
2. Enter the **Description**.
3. Check the **Enabled** box.
4. Verify the **Path of File to open**.
5. Enter the Optional command line arguments.

To use the patient number:
/p”[LName], [FName]::[SSN]::[PatNum]::[Birthdate]::[Gender]"

To use the chart number:
/p”[LName], [FName]::[SSN]::[ChartNum]::[Birthdate]::[Gender]"

6. Set up a clickable bridge button.
   1. Under **Add a button to these toolbars**, highlight where to display the button.
   2. Enter the **Text on button**.
   3. (Optional) Import an image to show on the button (22 x 22 pixels).
   4. Click OK.

**Technical Details**

Ateryx uses the patient number to identify selected patients. Open Dental will send the selected patients birthdate, chart number (if selected), gender, name, patient number, and SSN to Ateryx. If the patient does not exist, a new patient record is created.

**XV Sync**: A tool used for enterprises to keep their clinic databases (image folders) synced. [http://www.apteryx.com/xv-sync](http://www.apteryx.com/xv-sync)

**Name Grabber**: A tool created by Ateryx for practice management software that does not provide built-in bridges. We do not recommend Name Grabber with Open Dental because the tool will attempt to grab the patient name from the title bar of Open Dental instead of Open Dental sending the patient information to Ateryx. If the tool is used beware the patient number between the two softwares will not match and will eventually need to be corrected. Also, there may be issues with the tool selecting the correct patient if the patient name is misspelled, changes or there are duplicate names. For the Ateryx Name Grabber and DataDrill (bridge) version history: [http://www.apteryx.com/version-history](http://www.apteryx.com/version-history)

**Ateryx XVWeb Bridge**

In the **Main Menu**(592), click Setup, **Program Links**(934). Double-click on **XVWeb from www.apteryx.com/xvweb**.
Apteryx XVWeb is a web-based imaging application. Website: http://www.apteryx.com/xvweb. Before activating the bridge, log into your xvweb account to ensure the XV Web service is active. See XV Web Integration(949) for information on viewing images in Open Dental.

To activate the bridge:
1. Check the Enabled box.
2. Double-click on a row in Additional Properties to change settings.
   1. You can use the PatNum (enter 0) or ChartNum (enter 1) as the patient ID.
   2. Enter your custom XV Web URL.
   3. Enter your XV Web Username.
   4. Enter your XV Web Password.
   5. Select the Image Category you would like images to save to.
   6. Select whether you would like to Save Images to the OpenDentImages folder. Enter yes or no.
   7. Enter the preferred Birthdate Format.
   8. Select the Image Quality.
3. Set up a clickable bridge button.
   1. Under Add a button to these toolbars, highlight where to display the button.
   2. Enter the Text on button.
   3. (Optional) Import an image to show on the button (22 x 22 pixels).
4. If using clinics, click Hide Button for Clinics. Select which clinics the button should display on.
5. Click OK.

Technical Details
A user name and password is required the first time the bridge is launched. Open Dental will send the selected patients birthdate (optional), chart number (if selected), gender (optional), name, and patient number to Aptyrx XVWeb. If the patient does not exist in XVWeb a new patient record will be created.

**XV Web Integration**

See [Aptyrx XVWeb Bridge](947).

Aptyrx XV Web is a web-based imaging application. You must activate the service with XV Web before using the integration in Open Dental.

To save images to a patient's Images module:

1. (Optional) Create a new Image Category to save XV Web images to. ([Definitions: Image Categories](869))
   
   1. In the [Main Menu](592), click Setup, [Definitions](835), Image Categories.
   
   2. Click Add.
   
   3. Enter the name of the XV Web folder.
   
   4. If you would like to view thumbnails in the Chart module, check Show in Chart Module.
   
   5. Click OK.

2. Set the folder as the default. In the main menu, click Setup, [Program Links](934), XV Web. Set the additional property for ImageCategory to the folder. Change the Save Images setting to yes.

- **Note:** If Save Images is set to no, the image will exist as a download, but will not allow editing or manipulation from the Images module until manually imported into the database.
- Open Dental will automatically retrieve images in XV Web, but will not automatically download them. You must still download images you would like to store in Open Dental.
- In the Chart module, images will show as downloaded thumbnails. If double clicked, a full size image will be downloaded.

**Troubleshooting**

If an error occurs during initial setup, verify username and password in the Program Link setup.

If you save an image to Open Dental by copy/pasting or importing, it will appear twice.

This feature will work more efficiently in offices that have a high speed internet connection. If you receive any errors, try refreshing the Images module or Chart module and try again.

**AudaxCeph Bridge**

In the [Main Menu](592), click Setup, [Program Links](934). Double-click on AudaxCeph in the list.
AudaxCeph is x-ray analysis software. Website: [http://www.audaxceph.com/](http://www.audaxceph.com/).

To enable the bridge:
1. Check the **Enabled** box.
2. Double click on a row in **Additional Properties** to change settings. You can use the PatNum (enter 0) or ChartNum (enter 1) as the patient ID.
3. Set up a clickable bridge button.
   1. Under **Add a button to these toolbars**, highlight where to display the button.
   2. Enter the **Text on button**.
   3. (Optional) Import an image to show on the button (22 x 22 pixels).
4. If using clinics, click **Hide Button for Clinics**. Select which clinics the button should display on.
5. Click OK.

You must have the AudaxCeph bridge open before you click the AudaxCeph bridge button in Open Dental. If a patient is selected in Open Dental, but AudaxCeph is already open with a different patient selected, clicking the bridge button will not change the patient.

**Technical Details**

Because of the AudaxCeph bridge, the following occurs:

Patient Status: Every patient opened in AudaxCeph will have a patient status of active, even if a different patient status (e.g. deceased, inactive) has been selected on the Edit Patient Information window in Open Dental.
Gender: There are three gender selections in Open Dental (male, female, unknown) and only two in AudaxCeph (male, female). All unknown genders in Open Dental are translated to a male gender in AudaxCeph.

How the bridge works: When the bridge is enabled, Open Dental creates an update.xml file in the installation folder which AudaxCeph will read from.

Anesthesia
A complete Anesthesia system for Open Dental is available from Big Idea Software, LLC. It offers electronic anesthetic records for both IV and GA cases, and an inventory system for keeping track of scheduled anesthetic medications.

A trial version may be downloaded from Big Idea’s website at www.bigideasoft.com.

Big Idea Software, LLC created and maintains this program. While it is compatible with Open Dental, we do not offer support for it.

BioPAK Bridge

To enable the bridge:
1. Check the **Enabled** box.
2. Verify the **Path of file to open**.
3. Double-click on a row in **Additional Properties** to change settings. You can use the PatNum (enter 0) or the ChartNum (enter 1) as the patient ID.
4. Set up a clickable bridge button.
   1. Under **Add a button to these toolbars**, highlight where to display the button.
   2. Enter the **Text on button**.
   3. (Optional) Import an image to show on the button (22 x 22 pixels).
5. If using clinics, click **Hide Button for Clinics**. Select which clinics the button should display on.
6. Click **OK**.

**Technical Details**

BioPAK uses the patient number to identify selected patients. Open Dental will send the selected patients birthdate, chart number (if selected), gender, patient number, and name to BioPAK. If the patient number does not exist, a new patient record is created. If the patient number does exists but the name does not match then it will give an error that the patient already exists. If the patient record is correct, update the name to match in both softwares.
CADI Bridge

In the Main Menu(592) click Setup, Program Links(934). Double-click on CADI from www.cadi.net.

CADI is an imaging software. It is a re-branded version of MediaDent Bridge(1018). Website: http://www.cadi.net

To enable the bridge:
1. Check the Enabled box.
2. Verify the Path of file to open.
3. Double-click on a row in Additional Properties to change settings.
   1. You can use the PatNum (enter 0) or ChartNum (enter 1) as the patient ID.
   2. Verify Image Folder path.
3. Set up a clickable bridge button.
   1. Under Add a button to these toolbars, highlight where to display the button.
   2. Enter the Text on button.
   3. (Optional) Import an image to show on the button (22 x 22 pixels).
4. If using clinics, click Hide Button for Clinics. Select which clinics the button should display on.
5. Click OK.
Technical Details
CADi version 6.10.x is MediaDent is version 4.

CallFire Bridge
CallFire is an obsolete Program Link(934). Use Open Dental's two-way Integrated Texting feature instead.

Call Fire released an upgraded version of their text messaging interface in 2016. This new version does not integrate with Open Dental. CallFire notified us on December 23, 2015 that they will continue to support their old legacy interface for customers who continue to use it. Open Dental will no longer support the CallFire bridge, so we may not be able to address any issues you encounter.

Known Legacy CallFire Limitations:

- Only for outbound text messages.
- Messages have a 160 character limit.
- Do not use carriage returns (press Enter) or the message will be cut off at the carriage return when the message is sent.
- The following characters are allowed: a-z, A-Z, 0-9, . ; ; ! ? ( ) ~ = + - \ / @ $ # & %; . If other characters are used the message will fail.

CamSight Bridge
In the MainMenu(592), click Setup, Program Links(934). Double-click on CamSight from www.camsight.com.
CamSight is digital imaging software. Website: [http://www.camsight.com/](http://www.camsight.com/). This bridge is also used for Denttio. Website: [http://denttio.com/](http://denttio.com/).

To enable the bridge:
1. Check the **Enabled** box.
2. Verify the **Path of file to open**.
3. Double-click on a row in **Additional Properties** to change settings. You can use the PatNum (enter 0) or ChartNum (enter 1) as the patient ID.
4. Set up a clickable bridge button.
   1. Under **Add a button to these toolbars**, highlight where to display the button.
   2. Enter the **Text on button**.
   3. (Optional) Import an image to show on the button (22 x 22 pixels).
4. If using clinics, click **Hide Button for Clinics**. Select which clinics the button should display on.
5. Click OK.

**Technical Details**
CamSight uses the patient number to identify selected patients. Open Dental will send the patients birthdate, chart number (if selected), name, patient number, and SSN to CamSight. If the patient does not exist, a new patient record is created.

If you already have existing patients in CamSight make sure the numbers match Open Dental prior to using the bridge. To change the patient numbers to match both softwares, either use chart numbers and edit the chart number in Open Dental to match CamSight or edit the patient ID in CamSight to match Open Dental.
CaptureLink Bridge

In the MainMenu, click Setup, Program Links. Double-click on CaptureLink from www.henryschein.ca.

CaptureLink/SafeCom Image is a digital imaging software. Website: https://hsdigitalsolutions.wordpress.com/safecom-products/safecom-image/.

To enable the bridge:
1. Check the Enabled box.
2. Verify the Path of file to open.
3. Double-click on a row in Additional Properties to change settings. You can use the PatNum (enter 0) or ChartNum (enter 0) as the patient ID.
4. Set up a clickable bridge button.
   1. Under Add a button to these toolbars, highlight where to display the button.
   2. Enter the Text on button.
   3. (Optional) Import an image to show on the button (22 x 22 pixels).
4. If using clinics, click Hide Button for Clinics. Select which clinics the button should display on.
5. Click OK.
Care Credit

Care Credit is a credit card for financing healthcare expenses.

In Program Links(934), double-click CareCredit.

If you do not see CareCredit listed, use the instructions below to add the Program Link.

Care Credit cards cannot be used with PayConnect, X-Charge, or PaySimple, so payments must be processed through Open Dental in the Account(150) module. Use the program link to access the Care Credit website from Open Dental.

Create a Program Link

1. From Program Links, click Add.
2. Enter Care Credit in the Description field.
3. Check the Enabled box.
4. Enter the web address in Path of file to open.
5. Enter the Text on button.
6. Choose the module where the toolbar button will show.
7. (Optional) Import an image to show on the button. The image must be 22 x 22 pixels.
8. If using clinics, click **Hide Button for Clinics**. Select which clinics the button should display on.
9. Click **OK**. You will now have a button for Care Credit in your Account module toolbar.

**Process Care Credit cards**

1. Make sure a payment type exists for Care Credit. See Definitions, Payment Types (879).
2. In the Account module, click **Payment** (158).
3. Select Care Credit under Payment Type.
4. Click OK.
5. Click the CareCredit button in the Account module to launch the Care Credit website.
6. Process the payment.

**Carestream Bridge**

In the **Main Menu** (592), click Setup, Program Links (934). Double-click on Carestream Ortho/OMS from www.carestreamdental.com.

This bridge is only for Carestream Ortho/OMS. For the standard Carestream bridge, use Trophy Bridge(1069).

To enable the bridge:
1. Check the Enabled box.
2. Verify the Path of file to open.
3. Double-click on a row in Additional Properties to change settings.
   1. You can use the PatNum (enter 0) or ChartNum (enter 1) as the patient ID.
   2. Verify the Patient.ini path. If changed, the value cannot exceed 150 characters.
3. Set up a clickable bridge button.
   1. Under Add a button to these toolbars, highlight where to display the button.
   2. Enter the Text on button.
   3. (Optional) Import an image to show on the button (22 x 22 pixels).
4. If using clinics, click Hide Button for Clinics. Select which clinics the button should display on.
5. Click OK.

Central Data Storage CDS Bridge
In the Main Menu(592), click Setup, Program Links(934). Double-click on Central Data Storage.
Central Data Storage (CDS) is off-site STaaS (storage as a service). To sign up and begin using their services, visit their website: Central Data Storage. Also see Online Backups(543).

The only purpose of the CDS bridge is to remove the CDS button from the Backup window.
1. Verify that Enabled is NOT checked.
2. Check Hide Unused Button.
3. Click OK.

Cerec Bridge
In the Main Menu(592), click Setup, Program Links(934). Double-click on Cerec from Sirona.
Cerec is digital imaging software. Website: https://www.cereconline.com/.

To enable the bridge:
1. Check the Enabled box.
2. Verify the Path of file to open.
3. Double-click on Additional Properties to change settings. You can use the PatNum (enter 0) or ChartNum (enter 1) as the patient ID.
4. Set up a clickable bridge button.
   1. Under Add a button to these toolbars, highlight where to display the button.
   2. Enter the Text on button.
   3. (Optional) Import an image to show on the button (22 x 22 pixels).
4. If using clinics, click Hide Button for Clinics. Select which clinics the button should display on.
5. Click OK.

CleaRay Bridge
CleaRay is USB intraoral x-ray imaging software. Website: [http://www.clearydental.com/](http://www.clearydental.com/).

To enable the bridge:
1. Check the **Enabled** box.
2. Verify the **Path of file to open**.
3. Double-click on **Additional Properties** to change settings. You can use the PatNum (enter 0) or ChartNum (enter 1) as the patient ID.
4. Set up a clickable bridge button.
   1. Under **Add a button to these toolbars**, highlight where to display the button.
   2. Enter the **Text on button**.
   3. (Optional) Import an image to show on the button (22 x 22 pixels).
5. If using clinics, click **Hide Button for Clinics**. Select which clinics the button should display on.
6. Click OK.

**CliniView Bridge**

In the **Main Menu** (592), click Setup, **Program Links** (934). Double-click on **CliniView**.
To enable the bridge:
1. Check the **Enabled** box.
2. Verify the **Path of file to open**.
3. Double-click on **Additional Properties** to change settings. You can use the PatNum (enter 0) or ChartNum (enter 1) as the patient ID.
4. Setup up a clickable bridge button.
   1. Under **Add a button to these toolbars**, highlight where to display the button.
   2. Enter the **Text on button**.
   3. (Optional) Import an image to show on the button (22 x 22 pixels).
4. If using clinics, click **Hide Button for Clinics**. Select which clinics the button should display on.
5. Click OK.

Note: If the cliniview bridge does not launch, you can instead use the Aptyrx Bridge(946).

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**ClioSoft/SOTA Imaging Bridge**

In the **Main Menu**(592), click Setup, **Program Links**(934). Double-click on **ClioSoft** from **www.sotaimaging.com**.
ClioSoft/SOTA is digital imaging software. Website: [https://sotaimaging.com/](https://sotaimaging.com/). This bridge is also used for Harmony Imaging Software.

To enable the bridge:
1. Check the **Enabled** box.
2. Verify the **Path of file to open**.
3. Double-click on **Additional Properties** to change settings. You can use the PatNum (enter 0) or ChartNum (enter 1) as the patient ID.
4. Set up a clickable bridge button.
   1. Under **Add a button to these toolbars**, highlight where to display the button.
   2. Enter the **Text on button**.
   3. (Optional) Import an image to show on the button (22 x 22 pixels).
4. If using clinics, click **Hide Button for Clinics**. Select which clinics the button should display on.
5. Click **OK**.

**Technical Details**
ClioSoft uses the patients name and patient number to identify selected patients. Open Dental will send the patients birthdate (if after year 1880), chart number (if selected), patient number, and SSN to ClioSoft. If the patient does not exist, a new patient record will be created. The bridge will not work if the patients first name is blank in Open Dental or if the Additional Property Value is set to 1 and the chart number is blank in Open Dental.
DBSWIN Bridge

In the Main Menu(592), click Setup, Program Links(934). Double-click on DBSWin from www.duerruk.com.


To enable the bridge:
1. Check the Enabled box.
2. Double-click on a row in Additional Properties to change settings.
   1. You can use the PatNum (enter 0) or ChartNum (enter 1) as the patient ID.
   2. Verify the Text file path Value.
3. Set up a clickable bridge button.
   1. Under Add a button to these toolbars, highlight where to display the button.
   2. Enter the Text on button.
   3. (Optional) Import an image to show on the button (22 x 22 pixels).
4. If using clinics, click Hide Button for Clinics. Select which clinics the button should display on.
5. Click OK.

Troubleshooting
If you experience any file errors using this bridge, try running Open Dental and/or DBSWin as an administrator.

If DBSWin is not switching patients as expected, patients may need to have their Date of Birth entered in Edit Patient Information (62).

Demandforce Bridge
In the MainMenu (592), click Setup, Program Links (934). Double-click on DemandForce.

Demandforce is a marketing and communication platform for dental practices. Website: https://www.demandforce.com/

Note: As of February 2017, Demandforce no longer develops D3One. This bridge was implemented for this specific software. If you obtained D3One prior to its discontinuation, the bridge will work for you. Otherwise, D3One is no longer available.

To enable the bridge:
1. Check the Enabled box.
2. Change the Path of file to open to the Demandforce executable (e.g. demandforce.exe or d3one.exe).
3. Under Additional Properties, double click the Value cell then enter the Demandforce license key.
4. Set up a clickable bridge button.
   1. Under Add a button to these toolbars, highlight where to display the button.
   2. Enter the Text on button.
3. (Optional) Import an image to show on the button (22 x 22 pixels).
4. If using clinics, click **Hide Button for Clinics**. Select which clinics the button should display on.
5. Click OK.

**Technical Details**
The bridge will write out an XML file with all patient data. Use Demandforce to sync the XML file.

**DentalEye Bridge**

In the **Main Menu** (592), click Setup, **Program Links** (934). Double-click on **DentalEye**.

DentalEye is imaging software. This bridge can also be used for MiPACS Bridge (1020). Website: [http://www.dentaleyecom/](http://www.dentaleyecom/).

To enable the bridge:
1. Check the **Enabled** box.
2. Verify the **Path of file to open**.
3. Double-click on a row in **Additional Properties** to change settings. You can use the PatNum (enter 0) or ChartNum (enter 1) as the patient ID.
4. Set up a clickable bridge button.
   1. Under **Add a button to these toolbars**, highlight where to display the button.
   2. Enter the **Text on button**.
   3. (Optional) Import an image to show on the button (22 x 22 pixels).
   4. If using clinics, click **Hide Button for Clinics**. Select which clinics the button should display on.
   5. Click OK.

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**Dental Intel Bridge**

In the **Main Menu**(592), click Setup, **Program Links**(934). Double-click on **Dental Intel**.

Dental Intel integrates your practice management and accounting system data.

To sign up for Dental Intel and begin using their services, visit [http://unbouncepages.com/open_dental/](http://unbouncepages.com/open_dental/). You must be signed up for Dental Intel to use the bridge in Open Dental. Once set up, click the Dental Intel button in Standard Reports to launch your account on dentalintel.com.

To enable the bridge:
1. Check the **Enabled** box.
2. Enter the **Text on button**.
3. Verify the module the toolbar button will show in. Leave blank to show this button in the Reports window only.
4. If using clinics, click **Hide Button for Clinics**. Select which clinics the button should display on.
5. Click OK.

Note: To remove Dental Intel button from the Reports window, uncheck Enabled, then check **Hide Unused Button**.

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**DentalStudio Bridge**

In the [Main Menu](#) (592), click Setup, **Program Links** (934). Double-click on **DentalStudio**.

The DentalStudio bridge is an imaging software. See [https://www.villaus.com/](https://www.villaus.com/).

Contact DentalStudio to get a copy of the file AutoStartup.exe. Copy this file into the DentalStudio program folder.

To enable the bridge:
1. Check the **Enabled** box.
2. Verify the **Path of file to open**.
3. Double-click on a row in **Additional Properties** to change settings.
   1. You can use the PatNum (enter 0) or ChartNum (enter 1) as the patient ID.
   2. UserName (cannot contain double quotes).
   3. Password (cannot contain double quotes).
4. Set up a clickable bridge button.
   1. Under **Add a button to these toolbars**, highlight where to display the button.
   2. Enter the **Text on button**.
   3. (Optional) Import an image to show on the button (22 x 22 pixels).
   4. If using clinics, click **Hide Button for Clinics**. Select which clinics the button should display on.
   5. Click OK.

**Technical Data**
The user has the option to clear out the UserName program property, which will cause the logged-in Open Dental user credentials to be sent to DentalStudio instead.

**DentalTek Bridge**
In the **Main Menu**(592), click Setup, **Program Links**(934). Double-click on **DentalTek Smart Office Phone**.

DentalTek offers a comprehensive suite of services including cloud hosting, VOIP phones integrated with Open Dental, discounts on supplies and labs, and patient communications. To sign up for DentalTek and begin using their services, visit [DentalTek](#). You must be signed up for DentalTek to use the bridge in Open Dental. Once the bridge is setup, phone numbers in Open Dental can be clicked to call the patient using DentalTek.
To enable the bridge:
1. Check the **Enabled** box.
2. Enter the **Text on button**.
3. Verify the module the toolbar button will show in. Leave blank to show this button in the Reports window only.
4. If using clinics, click **Hide Button for Clinics**. Select which clinics the button should display on.
5. Click OK.

**Note:** To remove DentalTek button from the Account Module, uncheck **Enabled**, then check **Hide Unused Button**.

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### DentalXChange Patient Credit Score Service

DentalXChange users can enable the Patient Credit Score Service to review patient credit scores.

In [Program Links](934), double-click on **DentalXChange Patient Credit Score from register.dentalxchange.com**.

To enable the bridge:
1. Sign up with DentalXChange. Contact DentalXChange for pricing and account setup.
2. Check the **Enabled** box.
3. Under **Add a button to these toolbars**, highlight where to display the button. **AccountModule** will be selected by default.
4. Edit the **Text on Button** (optional).
5. If using clinics, click **Hide Button for Clinics**. Select which clinics the button should display on.

When enabled, users can click the button in the toolbar to launch the DentalXChange Patient Credit Score site. Log in credentials for DentalXChange are entered in the [ClaimConnect Clearinghouse](#) (656) window.

Check **Hide Unused Button** to remove the button from the Account Module.

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**DentForms Bridge**

In the [Main Menu](#) (592), click Setup, Program Links (934). Double-click on **DentForms**.

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DentForms is an electronic forms software. Website: [http://www.medicatalk.com](http://www.medicatalk.com)

To enable the bridge:
1. Check the **Enabled** box.
2. Verify the **Path of file to open**.
3. Double-click on **Additional Properties** to change settings. You can use the PatNum (enter 0) or ChartNum (enter 1) as the patient ID.
4. Setup up a clickable bridge button.
   1. Under **Add a button to these toolbars**, highlight where to display the button.
2. Enter the **Text on button**.
3. (Optional) Import an image to show on the button (22 x 22 pixels).
4. If using clinics, click **Hide Button for Clinics**. Select which clinics the button should display on.
5. Click OK.

**AFP ProImage Eva Bridge**

In the **Main Menu** (592), click Setup, **Program Links** (934). Double-click on **ProImage from www.dent-x.com**.

AFP Imaging DBA Imageworks is a digital imaging program. Website: [https://www.imageworkscorporation.com/evasoft-software/](https://www.imageworkscorporation.com/evasoft-software/). Also known as Dent-X ProImage, Eva, or **EvaSoftBridge** (999).

**ProImage**: If you are having an issue with a new ProImage window launching instead of updating the existing window every time the bridge is used, please contact us. We are trying to resolve the issue and will notify you when fixed.

**Eva bridge**: EvaSoft must be running in the background for the bridge to work.

To activate the bridge:
1. Check the **Enabled** box.
2. Verify the **Path of file to open**.
3. Double-click on **Additional Properties** to change settings. You can use the PatNum (enter 0) or ChartNum (enter 1) as the patient ID.
4. Set up a clickable bridge button.
   1. Under **Add a button to these toolbars**, highlight where to display the button.
   2. Enter the **Text on button**.
   3. (Optional) Import an image to show on the button (22 x 22 pixels).
4. If using clinics, click **Hide Button for Clinics**. Select which clinics the button should display on.
5. Click OK.

**Technical Details**

The ProImage database is based on the patient number. Open Dental sends the patient number, last name, first name, date of birth, address, etc. to ProImage. If the patient does not exist, a new patient record is created.

Warning: If the patient number exists but the additional information sent does not match, the patient record will be updated to match the patient information from Open Dental.

You should check your ProImage patient records to confirm the information matches Open Dental before using the bridge. To check:

1. Select the patient in ProImage from the Update Patient button located in the upper left or File menu. If it is not visible, enable the button from the Advanced settings under the Edit menu, Preferences then Toolbar Style.
2. Select the same patient in Open Dental.
3. Compare the ID in ProImage with the Patient Number in Open Dental. They must match before you can use the bridge.
4. If they don't match, change the patient ID in ProImage to match the patient number in Open Dental (you cannot change the patient number in Open Dental). To print a list of names and patient numbers run this Query:
   ```sql
   SELECT PatNum AS PatID, LName, FName, Birthdate FROM patient ORDER BY LName, FName
   ```

**Dexis Bridge**

In the **Main Menu**(592), click Setup, **Program Links**(934). Double-click on **Dexis**.
Dexis is imaging software. Website: http://www.dexis.com.

To enable the bridge:
1. Check the Enabled box.
2. Verify the Path of file to open.
3. Double-click on Additional Properties to change settings.
   1. You can use the PatNum (enter 0) or ChartNum (enter 1) as the patient ID.
   2. Verify that the InfoFile path is a full file path.
3. Set up a clickable bridge button:
   1. Under Add a button to these toolbars, highlight where to display the button.
   2. Enter the Text on button.
   3. (Optional) Import an image to show on the button (22 x 22 pixels).
4. If using clinics, click Hide Button for Clinics. Select which clinics the button should display on.
5. Click OK.

Technical Data
The bridge sends patient data from Open Dental to the specified text file. Example file:

Mouse, Mickey 02/24/08 (17)
PN=17
LN=Mouse
Open Dental then launches Dexis, passing the file name as a command line argument. Example: C:\DEXIS\DEXIS.EXE @InfoFile.txt

The patient number is the only required field in the text file. This means that Dexis likely organizes everything by patient number, and that patient numbers must be identical with those in Open Dental. This is not a problem for new setups with no patients entered in Dexis yet. But it may present a problem if you already have a number of patients entered in Dexis before you begin using Open Dental. The solution is to change the patient IDs in Dexis to match those in Open Dental. If Open Dental creates a new patient ID# which is different from the old Dexis ID#, you can easily fix it even if you have images in both Dexis charts. In the Dexis Admin window, scroll to the old patient ID# and click Modify Patient. Change the ID# manually to the new Open Dental ID#. The two Dexis charts will be merged into one. It can be easily done on a case by case basis as needed. After a while all your active patients will only have one ID# that matches their OD ID#.

Conversions
If you were using Dexis in stand alone mode, and/or the patient IDs do not match between your Dexis database and your Open Dental database, then you can contact Dexis to have them renumber the Dexis patient IDs. Dexis will usually renumber patient IDs for their customers for free (or at a nominal price). In order for Dexis to renumber the patient IDs they will request a spreadsheet containing certain patient information (patient ID, last name, first name, middle initial, and date of birth). Open Dental can provide you with this spreadsheet.

Troubleshooting
Error: Could not access C:\DEXIS\DEXIS.EXE
Possible Solutions:
- Usually this means that Dexis is not installed in the location specified for Path of file to open.
- If it is properly installed in the location and can run outside of Open Dental, usually the issue is that the current user has permission issues on the directory containing the file Infofile.txt. The default location for this file is C:\Program Files\Open Dental. This can be resolved by setting the InfoFile path to blank.
- You may need to always run Open Dental as administrator for Dexis bridge to work if the path to the Dexis.exe file is already correct. You can set the Open Dental shortcut to always run as administrator by right clicking the icon and selecting Properties.

Digora Soredex Optime Bridge
In the Main Menu(592), click Setup, Program Links(934). Double-click on Digora from www.soredex.com.
Soredex is an imaging system also known as Digora. The Digora bridge works for versions up to 2.1. Website: https://www.kavo.com/en-us/?lang=en-us.

To enable the bridge:
1. Check the Enabled box.
2. Verify the Path of file to open.
3. Double-click on Additional Properties to change settings. You can use the PatNum (enter 0) or ChartNum (enter 1) as the patient ID.
4. Set up a clickable bridge button.
   1. Under Add a button to these toolbars, highlight where to display the button.
   2. Enter the Text on button.
   3. (Optional) Import an image to show on the button (22 x 22 pixels).
4. If using clinics, click Hide Button for Clinics. Select which clinics the button should display on.
5. Click OK.

Technical Details
- The Digora bridge uses the Windows clipboard to pass commands to Digora. We used the specifications for Digora 2.1 dated 6/26/2002, although it almost certainly works with later versions as well.
- Digora must be running when the bridge button is clicked in Open Dental. If not, you may see an error or no action will occur.
- Digora will not automatically be brought to the focus when the bridge button is clicked in Open Dental.

Clicking the bridge button in Open Dental will put a string similar to this on the clipboard:
$DIGIN$ OPEN -n"Smith, John" -c"1234" -r -a

This should trigger Digora to open the patient card for the specified name and code pair. In the example above, the name is Smith, John and the patient code is 1234. If the patient doesn't exist in Digora, the -r flag that you see above tells Digora to create that new patient. The -a flag tells Digora to change focus to itself.

**Troubleshooting**: Close Digora, click the Digora button in Open Dental, then open a text editing program and paste so you can see the command Digora adds to the clipboard.

**Potential pitfalls**: We don't know how Digora monitors the clipboard so that it knows when a command is present. There might be a setting in Digora that needs to be turned on in order to enable the clipboard monitoring. This is not addressed in the bridge specifications we were provided.

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**Divvy Bridge**

Divvy automates direct mail messages.

In the *Main Menu* (592), click Setup, *Program Links* (934). Double-click on *Divvy*.

To enable the bridge:
1. Check the **Enabled** box.
2. Double-click on a row in **Additional Properties** to change settings.
   1. Enter your Divvy **Username**.
   2. Enter your Divvy **Password**.
   3. Enter the **AP Key**.
   4. Enter a value of **DesignID for Recall Cards**.
5. If using clinics, click **Hide Button for Clinics**. Select which clinics the button should display on.
6. Click OK.

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**Docpoint Bridge**

See [Program Links](934).

Docpoint synchronization application is a tool that transfers appointment data from Open Dental to Docpoint Web Service, and vice versa. This tool works as a cross vendor database replication to carry out, create, update, and cancel operations, in a cycle that is executed every 1 minute.

Open Dental does not maintain the Docpoint application. Any question on use of the program should be directed to Docpoint.

For U.S. operations: [www.docpoint.com](http://www.docpoint.com) and Puerto Rico: [www.docpoint.com/pr](http://www.docpoint.com/pr).

**How it Works**

Docpoint creates a local database (SQLite) on the client machine which works as an intermediate layer to keep track of every appointment created from Open Dental and Docpoint. This layer also works as a buffer in case of an internet outage.

**Transferring data from Open Dental to Docpoint**: Does not require any writes on Open Dental database.

**Create appointment**:
1. Select appointments newly created appointments:
   ```
   SELECT AptNum, PatNum, ProvNum, Date(AptDateTime) as date, Time(AptDateTime) as time, Pattern, ProcDescrip FROM appointment WHERE Date(AptDateTime) >= ? AND AptNum > ? AND AptStatus = 1 ORDER BY AptNum LIMIT ?
   ```
2. Docpoint application stores this data in the SQLite database.
3. A Docpoint process reads the appointments created in the SQLite database and sends to Docpoint Web Service through an HTTP API call. The appointments will be created on Docpoint if they pass the validation rules, and are sent over the appointment_docpoint_ids for the created appointments.
4. Docpoint stores the appointment_docpoint_id into the SQLite database. At this point each appointment will have two identifiers: one for Open Dental and one for Docpoint. These mapping identifiers will be useful for all future steps.

**Update appointment**:
1. Similar to creating appointments, Docpoint periodically checks for updates made on appointments (e.g. rescheduled appointments) using the same query for selected new appointments with parameter variations.
2. Docpoint stores an update even on SQLite database.
3. Docpoint then sends updated appointments and gets the confirmation from the web service.

**Delete appointments**:
1. Docpoint selects deleted appointments by using an AptStatus filter.
2. Docpoint stores a delete even on SQLite database.
3. As usual events are send to Docpoint web service and get a confirmation.

**Transferring data from Docpoint to Open Dental**: Requires writes on Open Dental Database.

Creating and updating appointments:
1. Desktop application asks Web service for the latest created appointments through an HTTP API call `get_appointments`. This call will return all appointments relevant to the practice (for multiple providers if present).
2. Desktop application then stores the information of each appointment into the SQLite database and inserts an update or create event depending on whether the appointment is present in the SQLite database.
3. An insert query is executed on the Open Dental database if:

   ```sql
   ```

   If the patient does not exist in the system then it will create one using this query:

   ```sql
   ```

   Or it will update the appointment if it already exists through:

   ```sql
   UPDATE appointment SET AptDateTime=?, Pattern=? WHERE AptNum = ?
   ```

Delete appointment:
1. The application asks Docpoint Web Service about the latest deleted appointments through HTTP API call `get_deleted_appointments`.
2. Then the application modifies the SQLite database and adds delete events.
3. Finally it will execute the following query for each deleted appointment:

   ```sql
   UPDATE appointment SET AptStatus=0 WHERE AptNum = ?
   ```

The application gives the client an option to make two-way synchronization or just one-way where the application only transfers data from Open Dental to Docpoint without writing anything on the database. If a two-way sync is selected, the application has to write on appointment and patient tables. Also the application comes in with a database backup feature that could be disabled as well. Database backup creates a daily backup folder that contains the Open Dental database.

Example: If Open Dental database resides in: `C:\mysql\data\cpatientdate` then database would look like `C:\mysql\data\cpatientdate_2013-9-5`

The application handles internet outage gracefully since it stores every event on its local database. It also handles racing condition very well, so when a practice runs the application for the first time, and has 2000 unsynchronized appointments, the application will segment the workload and execute events in manageable bundles.

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**Dolphin Bridge**

In the [Main Menu](#) (592), click Setup, [Program Links](#) (934). Double-click on **Dolphin from dolphinimaging.com**.
Dolphin is imaging software. Website: [https://www.dolphinimaging.com/](https://www.dolphinimaging.com/).

To enable the bridge:
1. Check the **Enabled** box.
2. Verify the **Path of file to open**.
3. Double-click on a row in **Additional Properties** to change settings.
   1. You can use the PatNum (enter 0) or ChartNum (enter 1) as the patient ID.
   2. Verify the path for **Filename**.
4. Set up a clickable bridge button.
   1. Under **Add a button to these toolbars**, highlight where to display the button.
   2. Enter the **Text on button**.
   3. (Optional) Import an image to show on the button (22 x 22 pixels).
4. If using clinics, click **Hide Button for Clinics**. Select which clinics the button should display on.
5. Click OK.

**Technical Details**

The bridge uses two programs:

- **C:\Dolphin\dolDb.exe** Passes information to Dolphin using the specified file. Text is written to a file, and then Dolphin imports it.
- **C:\Dolphin\dolCtrl.exe** Launches Dolphin using the specified patient id.
Everything is based on patient IDs. All changes to patient data are made from within Open Dental, and then kept automatically synchronized based on patient ID. The only time that synchronization is performed is when using the bridge to launch a patient in Dolphin. Open Dental never deletes patients from Dolphin.

**Dr. Ceph Bridge**

In the [Main Menu](592), click Setup, [Program Links](934). Double-click on Dr. Ceph from [www.fyitek.com](http://www.fyitek.com).

Dr. Ceph is an orthodontic imaging software. Website: [https://fyitek.com/software/drc ephem](https://fyitek.com/software/drc ephem).

To enable the bridge:
1. Check the **Enabled** box.
2. Verify the **Path of file to open**.
3. Double-click on a row in **Additional Properties** to change settings. You can use the PatNum (enter 0) or ChartNum (enter 1) as the patient ID.
4. Set up a clickable bridge button.
   1. Under **Add a button to these toolbars**, highlight where to display the button.
   2. Enter the **Text on button**.
   3. (Optional) Import an image to show on the button (22 x 22 pixels).
4. If using clinics, click **Hide Button for Clinics**. Select which clinics the button should display on.
5. Click OK.
DXIS Bridge

In the **Main Menu** (592), click **Setup**, **Program Links** (934). Double-click on **DXIS from dxis.com**.

DXIS is an imaging system that is no longer sold. Website: [http://www.dxis-net.com/_NS/EN/index.htm](http://www.dxis-net.com/_NS/EN/index.htm).

To enable the bridge:
1. Check the **Enabled** box.
2. Verify the **Path of file to open**.
3. Set up a clickable bridge button.
   1. Under **Add a button to these toolbars**, highlight where to display the button.
   2. Enter the **Text on button**.
   3. (Optional) Import an image to show on the button (22 x 22 pixels).
4. If using clinics, click **Hide Button for Clinics**. Select which clinics the button should display on.
5. Click **OK**.
**EasyNotesPro Bridge**

In the Main Menu (592), click Setup, Program Links (934). Double-click on Easy Notes Pro from easynotespro.com.

To enable the bridge:

1. Check the Enabled box.
2. Verify the Path of file to open.
3. Verify the Optional command line arguments. Typically this does not need to change.
4. Set up a clickable bridge button.
   1. Under Add a button to these toolbars, highlight where to display the button.
   2. Enter the Text on button.
   3. (Optional) Import an image to show on the button (22 x 22 pixels).
4. If using clinics, click Hide Button for Clinics. Select which clinics the button should display on.
5. Click OK.
eClinicalWorks

eClinicalWorks (eCW) is a medical practice management software. Open Dental can provide dental capabilities for eCW customers.

Demo: Open Dental and eClinicalWorks

eClinicalWorks Website

If you are a new customer, or interested in learning about the process, see eCW New Customer Processes (992). Typically Open Dental technicians will perform the installation for you and help arrange initial training for staff.

Using Open Dental for eCW users

- Using the Open Dental / eCW Interface (995)
- eCW General Information (990) (Dental Visit Types, PDFs of Clinical Notes and Treatment Plans, Prescriptions, Medical History, EHR)
- eCW Patient Demographics (990)
- eCW Procedures (993) (Entering, Duplicate Procedures, Procedure Button for Full-mouth Series)
- eCW Fee Schedules (990)

Technical

- eCW Bridge Modes (988)
- eCW Installation and Bridge Setup (986)
  - eCW - Install Open Dental on a Workstation (991)
- eCW Technical Information (994) (Middle Tier, Backups, Technical Details)
- eCW Troubleshooting (994)
- Stopping Open Dental Services (1415) (follow the update sequence carefully for all updates)

For Open Dental support, contact us via email at implementations@opendental.com, or by phone.
eCW Installation

Typically an Open Dental support technician will install Open Dental and set up the eClinicalWorks(985) bridge for you, following the steps below.

Note: If a user turns on the eCW bridge, the existing passwords for all users will stop working. So before turning on the bridge, make sure the admin password in Open Dental is blank. After the bridge is turned on, then set your passwords.

Installation Path

If using Tight or Full integration, Open Dental must be installed to the same path on all computers in order for the bridge from eCW to work.

- Current recommendation: C:\Open Dental\  
- Also acceptable: C:\Program Files (x86)\Open Dental\.  

This path has to be typed in manually when installing to 32 bit computers. On those computers, the x86 path will not exist and will be created during installation.

The path C:\Program Files\Open Dental is not a good choice. 64 bit versions of Windows will NOT allow this path to be used for a 32 bit program like Open Dental.
Also see eCW Install Workstation(991).

Assistance will also be required from eCW installers to set this bridge path in eCW.

**Bridge Setup**

1. In the **Main Menu** (592), click Setup, Program Links, then double click on eClinicalWorks.

2. Check the Enabled box to turn the bridge on.
3. Select the **eCW Bridge Modes** (988) (Tight Integration, Standalone, Full).
4. Set the path(s) to the HL7 Synch Folders. The paths will be relative to the server computer, NOT the workstation you are on.
5. See **eClinicalWorks HL7** (793) and follow the instructions to install the OpenDentalHL7 service on your server.

**Optional Setup**

- Patient Fee Schedules (Tight mode only). In Tight Integration, users cannot edit patient fee schedules in Open Dental. Instead they are imported from incoming HL7 messages. To manually select fee schedules in Open Dental, check this
box. It will unhide the Family module and show a Fee Schedule picker. Fee Schedule automation will still work, but the user is allowed to change the fee schedule after it is initially set.

- Fee Schedule Changes (Full mode only). In Full mode, changes made to the fee schedules on the Edit Patient Information(62) are not normally saved and the OK button is disabled. Typically demographic information is not saved in Open Dental because it is overwritten every time an HL7 message for the patient is processed. There is a workaround to enable the save of Fee Schedule changes only. Any other changes made to the Edit Patient Information window will be overwritten.
  1. In the main menu, click Setup, HL7. See eCW HL7 Message Structure(797).
  2. In the Internal grid, select eCW Full Mode, then click Copy to copy the definition to the Custom grid.
  3. Double click on the custom definition to edit.
  4. Enter the values exactly as entered in the eClinicalWorks Setup window:
    In to eClinicalWorks = Outgoing Folder
    Out from eClinicalWorks = Incoming Folder
    OpenDental HL7 Server = OpenDental HL7 Server
    HL7 Service Name = HL7 Service Name

  5. Under Show Demographics (Address, etc), select Change. Note that warning that changes may be overwritten.
  6. Click OK, then restart the ODHL7 service so the new definition is used for processing/sending HL7 messages. The program link will remain enabled and the setting for manual or import from HL7 message will still be in effect.

- Send Quadrant as Tooth Number: Usually quadrant information shows as surface information in a claim. However, some insurance carriers require that quadrant information show as tooth number and may reject claims if it doesn’t. Check this box to send quadrant information as tooth number. If you have an HL7 generic definition enabled, this box will not show. Instead set the default for quadrant information on the HL7 Def Edit window.

- Hide Chart Rx Buttons: If unchecked, the Rx and eRx buttons will show in the Chart module toolbar. If checked, these two buttons will be hidden.

- Require Signatures for Procedure Notes: If checked, all procedure notes must be signed upon Finish and Send.

- Don't Allow Incomplete Procedure Notes: If checked, all procedure notes must be completed upon Finish and Send. If a note contains quotes "", then information must be filled in between the quotes, or the note is considered Incomplete.

**Standalone Mode**

If using Standalone mode, follow these instructions to set up the bridge.

1. Enable the eClinicalWorks bridge, selecting Standalone.
2. Follow the instructions for setting up the Open Dental eCW HL7 application.
3. Work with eClinicalWorks support to have eCW start sending HL7 messages to the folder. Only demographic messages will be sent (ADT). If the patient does not seem to exist in OD, or the demographic information for a patient is different, then trigger an ADT message from eCW, probably by resaving the patient information in eCW. Remember that the ChartNumber in OD will contain the PatientID from eCW.

**eCW Bridge Modes**

If using Open Dental with eClinicalWorks(985), there are three different bridging modes to consider. Each is described below.

**Tight Integration Mode**

This is the most common mode used. In this mode, patients are accessed in eCW first. Clicking a link will launch Open Dental for the same patient. Open Dental is closed to transfer the user back to eCW.

- You will only use Open Dental for clinical charting, and all completed procedures will then pass to eCW for billing.
- All other functions will be done in eCW:
  o All practice management functions (including patient selection, accounts, and appointments).
  o All bills.
  o Entering of medical information (medication, problems, allergies).
  o Patient and insurance claims.
  o EHR meaningful use data.
**Full Mode**
In this mode, features will show that you may not use, or that may be complicated to integrate into your processes. This is the only mode that allows users to send pre-authorizations from Open Dental. Most eCW users use Tight Integration instead.
In Open Dental you will have full access to most features including:

- **Insurance Plans** (1244)
- **Preauthorization** (293).
- The **Main Toolbar** (1649), including email, patient and referral letters, forms, and popups.

Insurance plans are only used for pre-authorizations, and in some cases to show more accurate insurance estimates. You will need to re-enter plan and subscriber information in Open Dental. You should discuss this benefit in detail with a specialist before using Full mode.

You will not have access to:

- The **Appointments Module** (1). You will still make appointments in eCW.
- Some sections of the **Account Module** (150). Since billing will still be done in eCW, some areas will be hidden.

**Standalone Mode**
In this mode, Open Dental runs as an entirely separate program. Patients added or demographic information changed in eCW are automatically synced in Open Dental, but no other information will transfer. The user has to log in twice, once for eCW and once for Open Dental. Primary keys must be used to uniquely identify patients in both systems. Because Open Dental has no control over the PatNum, the ChartNumber is used instead. As patients are added, Open Dental will attempt to fill in the ChartNumber field of existing patients to match the internal patient ID from eCW. Once ChartNumber field has been set, it allows straightforward future synchronization.

- In eCW, you will enter and edit all demographic information. If entered in Open Dental, changes may be overwritten by the sync process.
- In Open Dental you will:
  - Re-enter medications; they are not synched or copied from eCW.
  - Create bills for dental procedures. These will be entirely separate from bills created in eCW. Dental insurance information will need to be entered in Open Dental.
  - Create dental prescriptions. You will need to manually copy prescriptions entered in Open Dental to eCW's medical chart if needed.

**Choosing a Bridge Mode**
The simplest way to choose a mode is to answer one question: Are you already using Open Dental side-by-side with eCW?
- If yes, you would likely choose Standalone Mode.
- If you are an existing eCW customer, and have not yet started using Open Dental, you would likely choose Tight Integration.

**Changing modes:**

- Changing modes between tight and full is very simple and can be done at any time.
- Changing modes from tight/full to or from standalone is very complex and would involve a conversion service provided by programmers from both eCW and Open Dental, resulting in a significant fee. For example:
  - Switching from Tight Integration to Standalone will result in existing Open Dental accounts needing adjustments to avoid duplicate billing from both systems.
  - Switching from Standalone to Tight Integration will result in all account balances needing to be transferred to eCW.
**eCw Patient Demographics**

For eClinicalWorks(985) users, all patient demographic data originates in eCW and is passed to Open Dental. All synchronization is based on the patient ID.

Do not enter patient data in Open Dental. When patient demographic data is sent from eCW, it will automatically overwrite all data in Open Dental for the matching patient ID without any user interaction. If the patient ID does not yet exist, then a new patient is created in Open Dental.

Patients that have a blank first name or blank last name in eCW will not be imported into Open Dental. If a patient has a blank first name or blank last name and the data for that patient is passed into Open Dental from eCW, then Open Dental will place a message in the Event Log to let the user know that the patient was not imported.

If using Tight Integration, you cannot edit patient demographic data in Open Dental.

**Merging Patients:** To merge patients you must first merge patients in eCW. Then, immediately afterwards, merge the same two patients in the same order in Open Dental. See [Merge Patients](1407). If patients are not merged in this manner, some information may not properly bridge between eCW and Open Dental.

**eCW Fee Schedules**

When using Open Dental with eClinicalWorks(985), in order to present accurate treatment plans to the patient, fee schedules must be present in Open Dental. You can export these fee schedules from eCW then import into Open Dental. See [Fee Schedules](914).

Note: Fees in Open Dental are strictly for treatment planning purposes. Fees charged to patients and submitted to insurance will be set by eCW. Changing a fee in Open Dental will not change the fee in eCW.

**Step 1:** Contact eCW to export your fee schedules.

**Step 2:** Create fee schedules in Open Dental, then import the .csv files.
1. In the Procedure Codes(1195), select a fee schedule.
2. Click Fee Tools(1210).
3. Click Import.

If there are procedure codes in the file that are not present in Open Dental, such as medical codes, those fees will not be imported.

Fee schedules are assigned automatically to patients using HL7 messages coming from eCW. The assignment is done based on fee schedule name, so the names must match exactly, including capitalization and spaces.

**eCW General Information**

Below is general information about using Open Dental with eClinicalWorks(985).

**Usernames and Passwords**

Users in Open Dental are automatically created when a user first launches Open Dental from eCW. The initial Open Dental password will match the user’s eCW password. If an eCW password changes, it also needs to be updated in Open
Dental. This can be done by logging into Open Dental using the old eCW password, then selecting File, Change Password.

**Dental Visit Types**

Every time you add a new visit type in eCW, contact eCW so they can update their interface.

**PDFs**

Two kinds of PDFs can be sent from Open Dental to eCW as part of the HL7 messages.
1. A copy of the Progress Notes (procedures in Chart module). This happens in the Edit Appointment(20) window when pushing the Finish & Send button or the Notes PDF button.
2. A Treatment Plan(283) gets sent every time a TP is saved using the Save button.

In eCW, the PDF files can be accessed in Patient Documents.

**Medical History (Tight Integration)**

Prescriptions, medications, problems, allergies, and medical history are entered into eCW and show in Open Dental's read only Medical(466).

**Prescriptions (Tight Integration)**

Prescriptions show in the read-only Medical window. For 32 bit operating systems they may show in the Progress Notes. Prescriptions should always be created in eCW. eCW will then create an identical prescription in Open Dental, viewable in the read-only Medical window.

- 32 bit Operating Systems: The New Rx button in Open Dental may launch the eClinicalWorks prescriptions window where you can create the prescription, depending on your eCW configuration. Changes to the prescription in eCW do not propagate to Open Dental, so create a new prescription or alter in both places if you must edit a prescription. Note that if you are upping a dosage it is a new prescription, not an edited one. Normally you will not edit prescriptions once made.
- 64 bit Operating systems: There is no New Rx button in Open Dental. Create the prescription in eCW.

**EHR**

- Tight Integration: eCW will be your Practice Management and EHR system for meaningful use. Open Dental only provides dental charting.
- Standalone mode: You can use eCW or Open Dental for EHR meaningful use, but not both. If you are going to use Open Dental, see Open Dental EHR.

**Updating to a New Version of Open Dental**

See Update(1639).

**eCW Install Workstation**

To install Open Dental on a client workstation properly, eClinicalWorks(985) customers need three items.

1. The Open Dental installation location (where eCW expects to find the OpenDental.exe file). It is almost always "C:\Open Dental" but can also be something else. If you are unsure of the install location, contact Open Dental.
2. The Setup.exe file for the current Open Dental version. It is located in the 'Setup Files' subfolder of the shared A to Z Folder(826) used by Open Dental (often \Server\OpenDentImages\SetupFiles). If you cannot locate the correct setup file, contact Open Dental.
3. The FreeDentalConfig.xml file from a working computer, located in the install directory (usually C:\Open Dental\FreeDentalConfig.xml).

Once you have the three items, to install Open Dental on a new workstation follow these steps.

1. On the new workstation, right click on the Setup.exe file and Run as administrator.
2. Change the installation directory to the directory where eCW expects to find the Open Dental.exe (#1 above.)
3. Copy the Freedentalconfig.xml file to the Open Dental installation directory.

The new workstation should now be operational.

### eCW New Customers

Below is an overview of a typical eClinicalWorks (985)/ Open Dental integration. For more information, contact a support technician.

- eClinicalWorks Customer Contract (PDF)
- New Customer Process (PDF)
- Customer Questionnaire (PDF)

### Things to Consider Early

- The implementation timeline is generally 6-8 weeks for interface installation, configuration, and testing.
- Plan for, and communicate, any data conversion needs as early as possible. It is important to develop a detailed plan for data migration. This may involve the eCW migration team and/or the Open Dental conversion team and mean down time for your office. Data conversion can be complex and involve multiple conversions. Planning is key.
  - Fees: If data migration is needed, there are data migration fees for eCW and conversion fees for Open Dental. Costs should be discussed with both Open Dental and your eCW Project Manager.
  - eCW performs PM data migration (e.g. demographics/appointments).
  - Open Dental performs EMR migration if needed. A TEST environment may be required if a TEST conversion is needed.
- Discuss your digital imaging needs with Open Dental.

### Implementation Steps

**Version Information:** Before Open Dental can be installed eCW version 9.0.35 or greater must be installed (with eCW). If you are using a load balancer, then eCW version 9.0.49 should be installed.

**Step 1: Open Dental Contract and Payment**
1. Contact an eCW sales representative and open a case requesting an Open Dental interface installation.
2. eCW will request that the customer contact Open Dental to obtain a contract. Email Open Dental at ecw@opendental.com or call 503-363-5432.
3. Sign and return the Open Dental contract. We will send you an invoice for payment.
4. Once payment is received, Open Dental will coordinate an Open Dental software installation.

**Note:** Important: Your customer name registered with eCW should match the customer name registered with Open Dental.

**Step 2: Interface Installation**
1. Review Open Dental HL7 server hardware requirements. See Computer Requirements.
2. Review technical information and details about eCW / Open Dental integration.
3. Once Open Dental is installed, eCW will schedule and perform an eCW interface installation.
4. After eCW has completed the interface installation, Open Dental will contact you to schedule an installation verification to make sure that the eCW / Open Dental interface is turned on and fully functional.
Step 3: Data Migration, Setup, and Training

- **Data Migration:** If data migration is needed we will schedule it after the interface installation is complete. The process requires close coordination between you, Open Dental, and eCW. Typically there is down time for the office.

- **Prepare for your Go Live Date.**
  - Your Go Live Date should be at least one week after installation verification.
  - Testing: Dedicate the week after installation verification to testing. This will minimize technical issues. For multiple locations, even longer lead time should be considered.
  - Training: Plan and schedule training for your staff. Open Dental provides one hour of online training per FTE provider. This is usually done as part of one or more group training sessions where users are connected to the Open Dental trainer via an internet meeting. For additional training options and prices, see [Fees for Software, Support, and Training](#).

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**eCW Procedures**

When using Open Dental in Tight Integration with eClinicalWorks(985), as procedures are completed in Open Dental, they are sent to eCW for billing and claim purposes. This section assumes that the appointment (encounter) was previously created in eCW.

**Send a Procedure to eCW**

1. Access Open Dental from eCW by selecting View Dental Chart. The VisitID/AptNum is passed silently to Open Dental and an appointment will show in the Chart. It was transferred there via HL7 within 70 seconds of the last appointment edit in eCW.
2. If you haven't already added today's treatment planned procedures, chart the procedures with status treatment planned. See [Enter Treatment(301)].
3. In the **Chart Module**(298), double click on today's appointment to see treatment planned procedures. Highlight the procedures to attach. Any other procedures that have been completed already will be automatically highlighted.
4. Verify the correct provider is attached to the appointment.
5. Change the appointment status from **Scheduled to Complete**, then click OK.
6. This will generate any default **Procedure Notes**(316), mark the procedures as **Complete** (which does not mean you are finished, only that these are the procedures you have done today), and apply the associated provider to the completed procedures.
7. If you use **Procedure Group Note**(479), highlight your completed procedures, then right click and select Group Note to enter.
8. During the course of the appointment, procedures may still be altered, added, removed, etc.
9. When patient treatment is done, open the appointment and check the procedures one last time for accuracy.
10. Signatures and procedure notes are verified prior to Finish & Send if boxes **Require Signatures for Procedure Notes** and **Don't Allow Incomplete Procedure Notes** are checked.
11. Click Finish & Send to close Open Dental and send the procedures to eCW. The Finish & Send button is labeled Complete prior to version 12.4.47.

If the procedures were sent incorrectly and need to be altered, open the appointment again and click Revise. This allows you to fix them in Open Dental. They will also need to be separately fixed in eCW. The user must have the security permission **EcwAppointmentRevise** in order to revise.

**Duplicate Procedures**

Duplicate procedures are checked for and removed from HL7 messages. In order to send more than one of the same procedure, there must be a distinguishing characteristic (e.g. tooth number, tooth range, surface, or procedure fee). The recommended property is tooth number. We do not recommend procedure fee.

- If it is a filling or crown, the distinguishing characteristic is Tooth Number.
- If a procedure doesn't have a tooth treatment area, create a dummy code that will have that treatment area. For example, to add multiple PA's, create a code D0230b with a treatment area of tooth. For each additional PA you complete for the patient, select a different tooth so they all show up in the HL7 DFT message. The HL7 service will remove any characters after the first five digits, so the 'b' would not be included in the DFT message.
**Full-mouth Series Procedure Button**

A custom procedure button can be set up to handle a 6 PA series. The button must be set up exactly like this:

- Procedure code for PA must be area *mouth*, and must have an abbreviation of *PA*. The ordinary PA code can be used.
- Procedure code for PA+ must be created that is different than the normal PA+ code. See Duplicate Procedures above.
  
The second PA+ code must have an area of *Tooth* and must have a abbreviation of *PA+*.
- A procedure button must be created so that is has these exact six codes on it: *PA, PA+, PA+, PA+, PA+, PA+*.

When the button is used, it will create a PA with no tooth number as well as 5 additional PAs with tooth numbers of 8, 14, 19, 24, and 30. These procedures will not trigger the duplicate procedures warning for HL7 because they have unique tooth numbers to distinguish them.

**eCW Technical**

This information is for more technical users of *eClinicalWorks*(985).

**Middle Tier**

The *Middle Tier* feature works well with eCW integration and is particularly helpful for security for multiple location clinics where displaying the patient in Open Dental is slow due to network speed. In the *Choose Database*(605) window, check the box for Using eCW.

**Backups**

It is extremely important to backup data as well as verify backup quality by restoring to a standalone MySQL server running on a different computer. Your backup plan should also include an off-site backup. See *Backups*(541).

**Technical Details**

This section is for programmers and power users only. It primarily refers to Tight Integration mode.

- See *Command Line Arguments* for information on how eCW communicates with Open Dental.
- See *Generic HL7*(784) for installation instructions and technical details.
- See *Multi-tenant Hosting* for instructions on how to host multiple customers on one database server.

**Errors**

See *eCW Troubleshooting*(994).

**eCW Troubleshooting**

Below are some common problems and solutions when using Open Dental and *eClinicalWorks*(985). Also see *eCW Technical*(994).

New features and bug fixes are constantly being added to the bridge. Frequently, problems can be fixed by updating to the most recent stable version of Open Dental. If your current version of Open Dental is compatible with the eCW version you are using, newer versions of Open Dental will also be compatible. If you are going to update your eCW version, it is a good idea to update your Open Dental version well ahead of time in case an eCW fix required changes to Open Dental.

Cases fixed by updating to most recent stable version of Open Dental:

- Provider Abbreviation issue: Enhanced on 7/8/2011 in Open Dental v.11.0 and eCW v. 9.0.33. provider.EcwID was added so that users could change their provider.Abbreviations without breaking the eCW-Open Dental interface.
- Load Balancer Issue: Fixed on 3/21/2013 in Open Dental v. 12.4.52 and 13.1.16, and eCW v. 9.0.49.
- Tomcat Authentication Issue: Fixed on 2/23/2012, in Open Dental v. 12.0.18 or 12.1.5, and eCW v. 9.0.35. This resolves this issue in regular tomcat environments.
For a few clients, eCW upgrades may not be an option, and they may need to go through eCW Release Management for approval of a customized fix without an eCW upgrade.

**Other Problems/Solutions**

**Problem: Medical panel will not load and an error message shows about a script failing.**
Solution: This may be an issue on Load Balancing Servers during heavy use hours of production, when many computers are accessing the eCW database at once. Update to version 14.1.9 or greater. In the [Main Menu](#) (592), click Setup, [Program Links](#) (934), eClinicalWorks, then check the [Exclude LBSESSIONID](#) box.

**Problem: UserName already in use when trying to change a user's password within Open Dental.**
Solution: If using a version of Open Dental prior to 12.2.29, the duplicate user names will need to be renamed so that they are unique, then they must be hidden. If using Open Dental v. 12.2.29 or later, the duplicate user names only need to be hidden.
1. In the [Security](#) (1106), double click on a duplicate user to edit.
2. Alter the user name so it is unique, then check the Is Hidden box.
3. Repeat for all duplicated users.
After names are unique and hidden, the password for the user you are logged in as can be changed.

**Problem: HL7 SIU messages are not created by eClinicalWorks if you Cut and Paste an appointment.**
Solution: After pasting, open the appointment in eCW and change the status for the appointment information from eCW to show up in Open Dental.

**Problem: The Finish & Send button not enabled inside the appointment.**
Solution: The Finish & Send button inside the appointment will only be enabled if the appointment was originally created in eCW and transferred to Open Dental (that is, only if the visitID matches the aptNum). If this is an issue please call Open Dental to troubleshoot.

**Using eCW**

Below are general steps for using Open Dental within the [eClinicalWorks](#) (985) interface.

1. In eCW, create the patient if one doesn't already exist.
2. In eCW, create the appointment. Select Dental as the Visit Type. If you create new dental visit types, open a ticket with eCW and request that they map them as Dental visit types.
3. From eCW, launch Open Dental. There are three ways:
   - From the Resource Scheduler, right click on the appointment and click View Dental Chart.
   - From the Progress Notes, click the green arrow next to Details, then click View Dental Chart.
   - From the Scheduling Button (aka the SO Jellybean), locate your encounter by specifying provider, facility, date, etc. Double click it to open.

Open Dental will launch with the Chart Module open:
4. Verify the appointment shows in the Clinical Notes, as well as any treatment planned procedures. If for today, the appointment and procedures will highlight yellow.

Note: It can take up to 60 seconds for the appointment to show in Open Dental. If you do not see it after this amount of time, contact us immediately at 503-363-5432 or ecw@opendental.com.

5. Add procedures to the chart for today and the future. See Chart Module(298), Enter Treatment(301), Treatment Plan Module(283).

6. Attach the procedures completed today to the appointment.
   - Double click on the appointment in the Clinical Notes. Any treatment planned procedures will show under Procedures on this Appointment.
   - Highlight the procedures to attach. They will turn light grey.
7. Click Finish and Send to send the procedures to eCW. This will set both the appointment and procedures complete. You only get one chance to send procedures to eCW using Finish and Send. If you make a mistake, or do not see Finish and Send, see Troubleshooting below. Hint: In Open Dental, open the appointment at any time and click Notes PDF to send an updated copy of your notes to the Patient Documents in eCW.

8. Verify that the procedures and any PDFs show in eCW.
   - Procedure Codes show in the patient's progress notes, under Billing Information (scroll to the bottom).

Billing Information:

**Visit Code:**

**Procedure Codes:**

- D0150 COMP ORAL EVALUATION – NEW/EST PT.
- D0330 PANORAMIC FILM SEE ALSO CODE 70320.
- D1110 PROPHYLAXIS – ADULT.

- PDFs of progress notes and any saved treatment plans show in the medical panel, under the DRTLA tab, Documents.
Note: If procedures show in the progress notes but the Progress Notes/Treatment Plan PDFs do not, open a ticket with eCW and tell them PDFs are not importing correctly from Open Dental.

**Troubleshooting**
- If you send the appointment and then realize the attached procedures are incorrect, you must manually fix the procedures in both Open Dental and in eCW.
- If you see a Revise instead of Finish and Send, the appointment has already been sent to eCW and cannot be sent again. The Revise button can be used to make changes, but they will not show in eCW
- If Finish and Send is grayed out, you must re-launch Open Dental from the correct appointment in eCW. Only the appointment that you use to launch Open Dental can be sent back to eCW.

**eRx Setup**
In the Main Menu(592), click Setup, Program Links(934), eRx.
See DoseSpot Setup(343) for instructions.

**Enabled:** Indicates if the bridge is enabled or disabled.

**eRx Solution:** Indicates which eRx solution is enabled (DoseSpot(338), Legacy eRx(349))

**Properties:** Enter Clinic ID and Keys (DoseSpot only).

For more information about electronic prescribing options in Open Dental, see eRx Companies(349).

**EvaSoft Bridge**

In the Main Menu(592), click Setup, Program Links(934). Double-click on EvaSoft.
EvaSoft is a digital imaging program from ImageWorks. Website: https://www.imageworkscorporation.com/evasoftware/. You can also use the bridge for AFP Imaging Bridge (973). Also known as Dent-X Prolmage and Eva.

To enable the bridge:
1. Check the Enabled box.
2. Double-click on Additional Properties to change settings. You can use the PatNum (enter 0) or ChartNum (enter 1) as the patient ID.
3. Set up a clickable bridge button.
   1. Under Add a button to these toolbars, highlight where to display the button.
   2. Enter the Text on button.
   3. (Optional) Import an image to show on the button (22 x 22 pixels).
4. If using clinics, click Hide Button for Clinics. Select which clinics the button should display on.
5. Click OK.

Technical Details
The Prolmage database is based on the patient ID. When you use the bridge, the patient ID gets sent along with name, birthdate, address, etc. If the patient ID is not found in the database, then it creates a new patient record. If the ID is found, and the information does not match, then it overwrites all existing patient name, address, etc, with the new information. This is a very important concept to understand if you already have patients in Prolmage before you start using it with Open Dental. It means that every single ID in your Prolmage database must be accurate, or you will suddenly find the names on each record being changed. Here’s how you should test your setup if you already have patients entered in Prolmage:
1. Open a patient information window in ProImage so you can see the name, id, address, etc. This might be easier said than done. We were never able to find a reliable way of doing this. We suggest trying the following. Try to use the Update Patient button at the upper left or in the File menu if you can find it. If it's not visible, try going to Edit, Preferences, Toolbar Style, Advanced. Then look for it again at the upper left.

2. Open the same patient in Open Dental. Go to the Family module, and open the patient edit window.

3. Compare the ID in ProImage with the Patient Number in Open Dental. They must match before you can use the bridge.

   You must edit the ID in ProImage to match the one in Open Dental.

4. If they don't match, then you need to go through every single patient in ProImage and change the ID to the Open Dental Patient Number. This can go quickly if you print a list ahead of time with all names and Patient Numbers from Open Dental. You can obtain and print such a list by running this query from Reports, User Query: You can copy and paste it into that window.

   SELECT PatNum AS PatID, LName, FName, Birthdate FROM patient ORDER BY LName, FName

5. You might have a unique situation where you happen to use chart numbers heavily in your office, possibly including letters such as SP0012. If that's the case, then you do have the option to use chart numbers as the patient ID in both programs, but it will take more work. The chart numbers must be entered for all patients in Open Dental. Also, if you have any existing patient records in ProImage, then you must be certain that the chart numbers are entered in the patient ID blank for all patients before using the bridge. So if you are certain that you want to use Chart Numbers, then go back to the Edit Program Link window shown above. Double click on the first row of additional properties, and change the 0 to a 1.

EvaSoft may ask if you want to set up Data Drill. This is not required since this bridge does the same thing.

**Ewoo Bridge**

This bridge was originally designed for EasyDent, an imaging product from ewoousa.com. That website is now defunct, and Ewoo was renamed to Vatech. Website: https://vatechamerica.com/products/ezdent-i.

This bridge can also be used for GoodDrs (DrsViewer Pro). https://gooodrs.us/.

To enable the bridge:
1. Check the Enabled box.
2. Verify the Path of file to open.
   Note: This bridge also supports EZ-Dent-i. To run EZDent-i, replace the Path of file to open with C:\Program Files (x86)\VATECH\EzDent-i\Bin\VTEzDent-iLoader32.exe.

3. Double-click on Additional Properties to change settings. You can use the PatNum (enter 0) or ChartNum (enter 1) as the patient ID.
4. Set up a clickable bridge button.
   1. Under Add a button to these toolbars, highlight where to display the button.
   2. Enter the Text on button.
   3. (Optional) Import an image to show on the button (22 x 22 pixels).
5. If using clinics, click Hide Button for Clinics. Select which clinics the button should display on.
6. Click OK.

**Technical Details**
The bridge sends patient data from Open Dental to an XML text file. Example file:

`<LinkageParameter>`
The text file is called linkage.xml, and is created in the same folder on the local computer as the EasyDent program is located.

Open Dental then launches EasyDent, which picks up the information in the linkage.xml file.

If no file is present, EasyDent will open with no patient selected.

If the patient is not recognized by EasyDent, a new patient will be created in EasyDent.

If you receive an error while launching, verify patient information is entered accurately (e.g. address, phone notes, etc.).

**Florida Probe Bridge**

In the **Main Menu** (592), click Setup, **Program Links** (934). Double-click on Florida Probe from [www.floridaprobe.com](http://www.floridaprobe.com).
Florida Probe is a periodontal charting software. Website: http://www.floridaprobe.com.

To enable the bridge:
1. Check the Enabled box.
2. Verify the Path of file to open.
3. Double-click on Additional Properties to change settings. You can use the PatNum (enter 0) or ChartNum (enter 1) as the patient ID.
4. Set up a clickable bridge button.
   1. Under Add a button to these toolbars, highlight where to display the button.
   2. Enter the Text on button.
   3. (Optional) Import an image to show on the button (22 x 22 pixels).
4. If using clinics, click Hide Button for Clinics. Select which clinics the button should display on.
5. Click OK.

Technical Details
If you have set a Windows system path, then fp32.exe will work as the Path of file to open.

Open Dental sends the following command line arguments:

```bash
fp32.exe /search /prompt /chart "&lt;PatNum or ChartNumber&gt;" /first &lt;first-name&gt;/last &lt;last-name&gt;
```

The following details used to be posted freely on the Florida Probe website:
/search performs a search on the database with the specified chart and name. The action performed depends on if /prompt is specified and if a matching record is found. If a record that matches the existing record is found, that entry will be opened. If a matching record isn't found, there are two actions that can be performed. If /prompt is specified, the user will be given a dialog informing them that a matching entry was not found. From here they can either create a new record (which will have the chart and/or name specified from the command-line), select a record to use instead, or cancel out of the program. If prompt is not specified, a new record will be created with the chart and/or name specified on the command-line. The /prompt command will not matter if the Host Application uses its own unique numbers for the chart number. If multiple entries exist that match the command-line specified parameters, the first one will be returned. prompt alters the action of the search, if no result was found. Without prompt specified, a new record with the chart and/or name specified will be created and immediately saved if an existing one was not found. With prompt specified, the user will be given a dialog box, allowing them to either select the 'correct' match, create a new user with the chart and/or name specified on the command-line, or cancel out of the program completely.

Searching is done based on the first name, last name and/or chart number specified. The search procedure works as follows: If more than one matching entry exists in the database, the first one will be returned, as listed in the database. It is assumed that the host Application will make sure that the chart numbers are kept unique, and use these to search. The first name is not used in searching, except for verification. The first name field also is not usable as a key, so specifying a first name, but neither a last name or chart number will bring up a new chart with that first name, then prompt the user to enter either a chart number or last name in order to save. The search will first search for an entry matching all specified fields. Then if that does not yield a match, and if a chart number was specified, it will search again based just on the chart number. If this leads to a match, the record with the matching chart number will be brought up, and the name fields will be updated with those specified on the command-line. It is assumed that the chart number is the master identification, and that for this case the person's name changed and was updated in the Host Application but not inside FP32. If a last name and first name are specified, but not a chart number, the search will fail if a record matching both the first and last name is not found. There is no additional search based just on the last name, although it will search for just the last name if no first name was specified.

Genoray Triana Bridge
In the **Main Menu**(592), click Setup, **Program Links**(934). Double-click on Triana from generayamerica.com.
Genoray Triana is an imaging software. Website: [http://www.genorayamerica.com/](http://www.genorayamerica.com/).

To enable the bridge:
1. Check the **Enabled** box.
2. Verify the **Path of file to open**.
   
   *Note: The Triana program may be installed in a different location.*

3. Double-click on a row in **Additional Properties** to change settings.
   1. You can use the PatNum (enter 0) or ChartNum (enter 1) as the patient ID.
   2. Enter the **Import.ini path**.
   3. Set up a clickable bridge button.
      1. Under **Add a button to these toolbars**, highlight where to display the button.
      2. Enter the **Text on button**.
      3. (Optional) Import an image to show on the button (22 x 22 pixels).
4. If using clinics, click **Hide Button for Clinics**. Select which clinics the button should display on.
5. Click **OK**.

**Technical Details**

Command Line: An example of the command line function that we use would be: `C:\Program Files\Triana\triana.exe -Fc:C:\Program Files\Triana\import.ini`

This command line will open Triana with the patient from the import.ini file. Programatically we update the `import.ini` when the user clicks the button.
Import.ini Path

[OPERATION]
EXECUTE=3 (required)
(Available 2: Open, 3: Registration and open/If he or she has been registered just reopen, 4: Only registration)

[PATIENT]
PATIENTID=Patient_ID(Chart No.) (Required)
FIRSTNAME=Patient_First_Name (Required)
LASTNAME= Patient_Last_Name
SOCIAL_SECURITY=Social_Security_Number
BIRTHDAY=YYYYMMDD (Ex: 19801231)
PATIENTCOMMENT=Patient comment (This will be blank)
GENDER= Sex_ID (Available 1: Male, 2: Female, 3: Another)

Guru Bridge
In the Main Menu(592), click Setup, Program Links(934). Double-click on Guru.
This bridge is currently in development. Website: https://www.gurudental.com/.

To enable the bridge:
1. Check the Enabled box.
2. Double-click on a row in Additional Properties to change settings.
   1. You can use the PatNum (enter 0) or ChartNum (enter 1) as the patient ID.
   2. Enter the Guru image path.
3. Setup a clickable bridge button.
   1. Under Add a button to these toolbars, highlight where to display the button.
   2. Enter the Text on button.
   3. (Optional) Import an image to show on the button (22 x 22 pixels).
4. If using clinics, click Hide Button for Clinics. Select which clinics the button should display on.
5. Click OK.

HandyDentist Bridge
In the Main Menu (592), click Setup, Program Links (934). Double-click on HandyDentist from handycreate.com.
HandyDentist is an imaging software. Website: [http://www.handycreate.com/](http://www.handycreate.com/).

To enable the bridge:
1. Check the Enabled box.
2. Verify the Path of file to open.
3. Double-click on Additional Properties to change settings. You can use the PatNum (enter 0) or ChartNum (enter 1) as the patient ID.
4. Set up a clickable bridge button.
   1. Under Add a button to these toolbars, highlight where to display the button.
   2. Enter the Text on button.
   3. (Optional) Import an image to show on the button (22 x 22 pixels).
4. If using clinics, click Hide Button for Clinics. Select which clinics the button should display on.
5. Click OK.

**Technical Details**
The bridge uses PatNum, FName and LName.

**HDX Will Bridge**
In the [Main Menu](#)(592), click Setup, [Program Links](#)(934). Double-click on [HDX WILL](#) from [www.hdx.co.kr](http://www.hdx.co.kr).
HDX Will is an imaging software. Website: [hdxwillna.com](http://www.hdxwillna.com).

To enable the bridge:
1. Check the **Enabled** box.
2. Verify the **Path of file to open**.
3. Double-click on **Additional Properties** to change settings.
   1. You can use the PatNum (enter 0) or ChartNum (enter 1) as the patient ID.
   2. Verify the **System path to HDX WILL Argument ini** file is correct.
3. Set up a clickable bridge button:
   1. Under **Add a button to these toolbars**, highlight where to display the button.
   2. Enter the **text on button**.
   3. (Optional) Import an image to show on the button (22 x 22 pixels).
4. If using clinics, click **Hide Button for Clinics**. Select which clinics the button should display on.
5. Click OK.

---

**HouseCalls Bridge**

TeleVox's HouseCalls delivers automatic appointment reminders.

In **Program Links** (934), double-click on **HouseCalls from www.housecallsweb.com**.
Check the Enabled box.

Double click on a row in Additional Properties to change settings.
1. You can use the PatNum (enter 0) or ChartNum (enter 1) as the patient ID.
2. Verify the Export Path.

Setup a clickable bridge button.
1. Under Add a button to these toolbars, highlight where to display the button.
2. Enter the Text on button. (Optional) Import an image to show on the button (22 x 22 pixels).
3. If using clinics, click Hide Button for Clinics. Select which clinics the button should display on.

**Technical Details**
The data is always exported to a file called Appt.txt in the Export Path specified. The file is a simple comma-delimited text file which has the following columns:

<table>
<thead>
<tr>
<th>Field</th>
</tr>
</thead>
<tbody>
<tr>
<td>LastName</td>
</tr>
<tr>
<td>FirstName (or we substitute Preferred Name if exists)</td>
</tr>
<tr>
<td>PatientNumber (Can be PatNum or ChartNumber, depending on what user selected)</td>
</tr>
<tr>
<td>HomePhone</td>
</tr>
</tbody>
</table>
WorkNumber
EmailAddress
SendEmail (this will be true if email address exists.)
Address
Address2 (although they did not offer this as an option)
CityStateZip
ApptDate
ApptTime
ApptReason (procedures descriptions-user can't edit)
DoctorNumber (for the Doctor, we currently use the patient primary provider. Otherwise, we would run into trouble with appointments assigned to a specific hygienist.)
DoctorName
IsNew
PatientWirelessPhone

When you click on the HouseCalls button, you get to select a date range of appointments to confirm:

Click OK to create the text file. The HouseCalls software will upload the text file sometime in the middle of the night.

Insurance Answers Plus

Note: This bridge no longer works with newer versions of Open Dental as of November 2017. Insurance Answers Plus is working on a plugin to return functionality. Contact IAP for more information.
Open Dental can bridge to the desktop version of Insurance Answers Plus (IAP): [www.insuranceanswersplus.com](http://www.insuranceanswersplus.com). IAP is currently only available in some states. Contact them for exact locational availability.

### Installation instructions:

1. Install Open Dental. Make sure you are on Open Dental version 7.0.41 or later.
2. Install IAPlus. Make sure you are on version 10 (unknown whether it works for versions greater than 10; 11/17/2011).
3. Copy iaplus10.dll from your IAPlus installation directory (usually `C:\IAPlus\`) to your `C:\Program Files\Open Dental\` folder.

Once you have installed the program, enable the program link in Open Dental:

1. In the [Main Menu](592), click Setup, [Program Links](934). Double click on IAP.
2. Check the Enabled box.
3. Verify the Path of file to open.
4. Click OK. The IAP button will appear on the Insurance Plan(81).

### Troubleshooting

Try running OD as administrator.

A common error is "File not found..". Check all three steps above to resolve this error.
iCat Bridge

In the MainMenu(592), click Setup, Program Links(934). Double-click on iCat from www.imagingsciences.com.

iCat is an imaging software. Website: https://www.kavo.com/en-us/i-cat

To enable the bridge:
1. Check the Enabled box.
2. Verify the Path of file to open.
3. Double-click on a row in Additional Properties to change settings.
   1. You can use the PatNum (enter 0) or ChartNum (enter 1) as the patient ID.
   2. Enter the Acquisition computer name.
   3. Verify XML output file path.
   4. Verify Return folder path.
5. Set up a clickable bridge button.
   1. Under Add a button to these toolbars, highlight where to display the button.
   2. Enter the Text on button.
   3. (Optional) Import an image to show on the button (22 x 22 pixels).
4. If using clinics, click Hide Button for Clinics. Select which clinics the button should display on.
5. Click OK.
Technical Details
In the Additional Properties grid, set the following properties:

**XML output file path:** This is a file that is created and managed by Open Dental. Every time this bridge is used from the acquisition computer, the current patient is added to the file. From within the iCat software, set this same path for the PM.XML file. The patients in this file will show on a list to select from in iCat when acquiring an image.

**Return folder path:** After a patient is selected in the iCat software, it will generate a response file in the specified folder. Open Dental will process this file to remove that patient from the PM.XML file.

**Acquisition computer name:** The name of the computer where the iCat acquisitions take place. The descriptions above all pertain to the acquisition computer. If you are on a different computer and you use the iCat bridge, it will behave totally differently. It will instead try to launch iCat software using a command line argument.

In the iCat software, turn off the option to have iCat return thumbnail images. Open Dental will disregard such images if they are created.

iCat returns an XML file with a small amount of information. The name of the return file will be in the following format: PatID_yyyymmddhhmss.xml Open Dental is not interested in any of the information within the file, but only in the filename itself. Open Dental extracts the PatID from the filename, removes the corresponding entry in PM.XML, and then deletes the file. If there is an error processing the return file from iCat, Open Dental will fail silently. The return file will not get deleted, and the patient entry will not be removed from the PM.XML file. If this happens, we will need to take a look at the PM.XML file as well as the return file. It is also safe to delete the entire PM.XML file at any time. This will completely clear the list of patients that show on the list to select from in iCat when acquiring an image.

i-Dixel Bridge
In the **Main Menu**(592), click Setup, **Program Links**(934). Double-click on **i-Dixel**.

To enable the bridge:
1. Check the Enabled box.
2. Verify the Path of file to open.
3. Double-click on Additional Properties to change settings. You can use the PatNum (enter 0) or ChartNum (enter 1) as the patient ID.
4. Set up a clickable bridge button.
   1. Under Add a button to these toolbars, highlight where to display the button.
   2. Enter the Text on button.
   3. (Optional) Import an image to show on the button (22 x 22 pixels).
5. If using clinics, click Hide Button for Clinics. Select which clinics the button should display on.
6. Click OK.

Technical Details
Optional command line arguments passed in for this bridge are [PatNum/ChartNum] [FirstName] [LastName] [Gender].
iRYS Bridge
In the MainMenu(592) click Setup, Program Links(934). Double-click on iRYS from www.cefladental.com.

To enable the bridge:
1. Check the Enabled box.
2. Verify the Path of file to open.
3. Double-click on Additional Properties to change settings. You can use the PatNum (enter 0) or ChartNum (enter 1) as the patient ID.
4. Set up a clickable bridge button.
   1. Under Add a button to these toolbars, highlight where to display the button.
   2. Enter the Text on button.
   3. (Optional) Import an image to show on the button (22 x 22 pixels).
4. If using clinics, click Hide Button for Clinics. Select which clinics the button should display on.
5. Click OK.

Technical Details
This bridge is the same as the RayMage bridge, but with birthdate and sex added to the command line arguments.

/PATID "123456"  /NAME "John"  /SURNAME "Smith" / BDATE "dd,MM,yyyy" / SEX "M"

The name and surname arguments will be the patient's first and last name with all spaces and quotes removed from them. If the patient ID already exists, then the corresponding patient folder is opened.

If the patient ID does not exist, then a new patient folder is created and opened. When a patient ID already exists and the patient name passed in does not match (for example when a patient name is updated), then a message box will display asking the user if they want to change the patient name and the patient folder corresponding to the existing ID is opened.

Note: We have received reports of IRYS version 8.0 not working well with Open Dental.

MediaDent Bridge


MediaDent is imaging software. Website: http://www.mediadentusa.com/. CADI Bridge (953) is a re-branded version of MediaDent.

To enable the bridge:

1. Check the Enabled box.
2. Verify the **Path of file to open**.
3. Double-click on a row in **Additional Properties** to change settings.
   1. You can use the PatNum (enter 0) or ChartNum (enter 1) as the patient ID.
   2. Verify **Text file path**.
   3. Enter **MediaDent version either 4 or 5**.
   4. Verify **Image Folder** path.
5. Set up a clickable bridge button.
   1. Under **Add a button to these toolbars**, highlight where to display the button.
   2. Enter the **Text on button**.
   3. (Optional) Import an image to show on the button (22 x 22 pixels).
4. If using clinics, click **Hide Button for Clinics**. Select which clinics the button should display on.
5. Click OK.

**Technical Details**

- **Text File Path**: Only used with version 5. Patient data will be written to a text file. You must make sure that the path specified is valid on all computers and that the user has Windows permission to write to that file. Warning! The default text file path is actually a poor choice because Vista does not normally allow users to write directly to the C drive. A better choice would be: `C:\Mediadent\MediadentInfo.txt`. But you would have to make sure to create a `C:\Mediadent` folder on each workstation and assign full read/write permissions to that folder in Windows. Also, you might have to specify a fully qualified path for the file to open in the text box further up. Like this: `C:\Program Files\Mediadent\Mediadent.exe`, or whatever the usual path is. The disadvantage of doing this is that the path might be different on 64 bit machines. So try the simpler path as shown above first.
- **MediaDent Version 4 or 5**: Enter either 4 or 5. In Version 6.6, the bridge was overhauled to include support for MediaDent v5.
- **Image Folder**: Only used with version 4. After upgrading to version 6.6, the Image Folder may have to be reentered.

**Midway Dental Bridge**

In the **Main Menu**(592) click Setup, **Program Links**(934). Double-click on **Midway Dental**.
Midway Dental is a dental supply company. Website: http://www.midwaydental.com/.

To enable the bridge:
1. Check the Enabled box.
2. Verify the Path of file to open.
3. Setup up a clickable bridge button.
   1. Under Add a button to these toolbars, highlight where to display the button.
   2. Enter the Text on button.
   3. (Optional) Import an image to show on the button (22 x 22 pixels).
4. If using clinics, click Hide Button for Clinics. Select which clinics the button should display on.
5. Click OK.

MiPACS Bridge
In the MainMenu(592), click Setup, Program Links(934). Double-click on MiPACS Imaging.
MiPACS is a digital dental imaging system. Prior to version 12.0, use the DentalEye Bridge (967) bridge. Website: www.medicorimaging.com.

To enable the bridge:
1. Check the Enabled box.
2. Verify the Path of file to open.
3. Double-click on Additional Properties to change settings. You can use the PatNum (enter 0) or ChartNum (enter 1) as the patient ID.
4. Set up a clickable bridge button.
   1. Under Add a button to these toolbars, highlight where to display the button.
   2. Enter the Text on button.
   3. (Optional) Import an image to show on the button (22 x 22 pixels).
4. If using clinics, click Hide Button for Clinics. Select which clinics the button should display on.
5. Click OK.

Mountainside Bridge
Mountainside software is a medical practice management software.

In the Main Menu (592), click Setup, Program Links (934). Double-click on Mountainside in the list.
Website: http://mountainsidesoftware.com/. Open Dental can provide dental capabilities for Mountainside customers.

To enable the bridge:
1. Check the Enabled box.
2. Enter the Out From Mountainside HL7 path.
   Note: The path will be relative to the server computer, not the workstation you are on.
3. Install the OpenDentalHL7 service on the server.

**Technical Details**

Any patients that are added or changed in Mountainside are automatically synced in Open Dental. Users should make changes to demographics in Mountainside rather than in OD, because their changes might otherwise be overwritten later by the sync process. There must be a primary key used to uniquely identify patients in both systems. Because Open Dental users do not have any control over the PatNum, the ChartNumber is instead used. As patients are added or changed in Mountainside, Open Dental will attempt to fill in the ChartNumber field of existing patients to match the internal patient ID from Mountainside. Once the ChartNumber field has been set in OD, it allows straightforward future synchronization.

**NewTom NNT Bridge**

In the Main Menu(592), click Setup, Program Links(934). Double-click on NewTom NNT from www.newtom.it.

To enable the bridge:
1. Check the Enabled box.
2. Verify the Path of file to open.
3. Double-click on Additional Properties to change settings. You can use the PatNum (enter 0) or ChartNum (enter 1) as the patient ID.
4. Set up a clickable bridge button.
   1. Under Add a button to these toolbars, highlight where to display the button.
   2. Enter the Text on button.
   3. (Optional) Import an image to show on the button (22 x 22 pixels).
4. If using clinics, click Hide Button for Clinics. Select which clinics the button should display on.
5. Click OK.

**Technical Details**
Optional command line arguments passed in for this bridge are [PatNum/ChartNum], [FName], [LName], [d,M,yyyy], [SSN].
In the Main Menu (592), click Setup, Program Links (934). Double-click on Office.

This bridge allows offices to attach a Microsoft Office or Open Office Writer document to a patient. This is commonly used to quickly store notes relevant to each patient without changing modules.

To enable the bridge:
1. Check the Enabled box.
2. Verify the Path of file to open.
3. Double-click on a row in Additional Properties to change values.
   1. You can use the PatNum (enter 0) or ChartNum (enter 1) as the patient ID.
   2. Document folder: The location where the patient’s documents reside (typically the path to the A to Z folder).
   3. File extension: Indicates the format of the file (e.g. doc, odt).
4. Setup a clickable bridge button.
   1. Under Add a button to these toolbars, highlight where to display the button.
   2. Enter the Text on button.
   3. (Optional) Import an image to show on the button (22 x 22 pixels).
5. If using clinics, click Hide Button for Clinics. Select which clinics the button should display on.
6. Click OK.

Technical Details
Because Microsoft Office/Open Office files are patient specific, a patient must be selected.
Note: When saving a new document in OpenOffice and there is a prompt to "Keep Current Format or Save in ODF Format ", it is recommended to Save in ODF Format.
Orion Bridge
The Orion bridge is rarely used.

In the [Main Menu](592), click Setup, [Program Links](934). Double-click [Orion](934).

To enable the bridge:
1. Check the [Enabled](92) box.
2. Click OK.

California Prison System
See [Orion Bridge](1025)

Installation
Set up a new Oracle schema or database using the two files we have posted on the Oracle page. This will result in a brand new database with a small amount of information in it. No information from the databases previously used for testing will be carried forward into this new database.

Using the ordinary Open Dental client program running on the server, connect directly to the database from the Choose Database(605) window for initial testing.

In the Data Paths(824) window, select the option half-way down to store images directly in the database without using A to Z folders(826).

Turn on Orion bridge in Program Links(934). Then restart Open Dental.

Follow the instructions on the Middle Tier page to also set up the middle tier on the server that the other workstations will be connecting to.

**Setting up Options**

In order to perform the next step, a patient must be currently selected as described in Select Patient(1649). If there are no patients in the database, a patient will need to be added as described in Family Add(1652).

Go to the Chart(298) module, Show Tab(328). Set up two chart views, one for Treatment Plan, and one for Progress Notes:
### Fields Showing

<table>
<thead>
<tr>
<th>Field Name</th>
<th>New Desc</th>
<th>Width</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date TP</td>
<td></td>
<td>67</td>
</tr>
<tr>
<td>Th</td>
<td></td>
<td>27</td>
</tr>
<tr>
<td>Description</td>
<td></td>
<td>218</td>
</tr>
<tr>
<td>Surf</td>
<td></td>
<td>40</td>
</tr>
<tr>
<td>DPC</td>
<td></td>
<td>33</td>
</tr>
<tr>
<td>Prov</td>
<td></td>
<td>42</td>
</tr>
<tr>
<td>User</td>
<td></td>
<td>62</td>
</tr>
<tr>
<td>Stat 2</td>
<td>Status</td>
<td>38</td>
</tr>
<tr>
<td>Schedule By</td>
<td></td>
<td>72</td>
</tr>
<tr>
<td>Stop Clock</td>
<td></td>
<td>67</td>
</tr>
<tr>
<td>ADA Code</td>
<td>Proc Code</td>
<td>62</td>
</tr>
<tr>
<td>Quadrant</td>
<td></td>
<td>55</td>
</tr>
</tbody>
</table>

### Available Fields

- Date
- Time
- Dx
- Stat
- Amount
- Signed
- Priority
- Date Entry
- On Call
- Effective Comm
- End Time

### Statuses

- TP
- C
- E
- R
- RO
- CS
- CR
- CA_Tx
- CA_EPRD
- CA_PD
- S
- ST
- W
- A
Create the Exam Sheets for "Oral Cancer Screening" and "PSR". The sheets that were already set up over the last few months can be exported from the old database and then imported into the new database to save time.

**Printing out Planned Appointment**

In Sheets(1123), set up a Patient Letter. Rename it Planned Appt Info. Change the layout to suit your needs. In the main static text box, add the field [plannedAppointmentInfo]. Save the sheet. To later print the info for the Planned Appointment for one patient, open that patient and click the Letter button the main toolbar. Pick the Planned Appt Info from the list.

**Multivisit Appointments**

Let's say there are 4 procedures in a multivisit sequence:

Appt 1: Denture Impressions- Set DPC to 2. (this also sets a schedule by date)
Appt 2: Bite - DPC none
Appt 3: Try-in - DPC none
Appt 4: Deliver - DPC none

The Deliver procedure would be the D code, while the other three would be dummy codes. For example, C5105 for denture impressions. At the first appointment, the first procedure is changed from TP to C, and the stop clock date is set for that procedure to match the date of service. Once the stop clock date is set for the first procedure, there is no time limit to complete the remaining procedures.

The query below can be used to determine when a case was started, the number of days between appointments, and the total number of days to complete case. It first finds any completed multivisit procedures with a stop clock date in the given range. It then shows all completed multivisit procedures with a date greater than or equal to the stop clock date.

```
SET @startdate=ADDDATE(CURDATE(),INTERVAL -2 MONTH);
SET @enddate=CURDATE();
SELECT pl.PatNum,pc.ProcCode,pl.ProcDate,op.DateStopClock
FROM orionproc op,procedurelog pl,procedurecode pc,patient p
WHERE op.ProcNum=pl.ProcNum AND
  pl.CodeNum=pc.CodeNum AND
  p.PatNum=pl.PatNum AND
  op.Status2=2 AND
  pc.IsMultiVisit='1' AND
  ((op.DateStopClock>=@startdate AND op.DateStopClock<=@enddate) OR
   pl.ProcDate>=op.DateStopClock)
ORDER BY p.LName,p.FName,pl.ProcDate
```

Instructions for using the query above can be found on the Query Favorites(1385) page.

**OrthoCAD Bridge**

In the Main Menu(592), click Setup, Program Links(934). Double-click on OrthoCAD from www.itero.com.
OrthoCAD is digital imaging technology for orthodontics. Website: http://www.itero.com/en-us.

To enable the bridge:
1. Check the Enabled box.
2. Verify the Path of file to open.
3. Double-click on Additional Properties to change settings. You can use the PatNum (enter 0) or ChartNum (enter 1) as the patient ID.
4. Set up a clickable bridge button.
   1. Under Add a button to these toolbars, highlight where to display the button.
   2. Enter the Text on button.
   3. (Optional) Import an image to show on the button (22 x 22 pixels).
5. If using clinics, click Hide Button for Clinics. Select which clinics the button should display on.
6. Click OK.

Ortho Insight 3D Bridge
In the Main Menu (592), click Setup, Program Links (934). Double-click on Ortho Insight 3d from http://www.motionview3d.com.
Ortho Insight 3D is an imaging software. Website: [http://motionview3d.com](http://motionview3d.com)

To enable the bridge:
1. Check the **Enabled** box.
2. Verify the **Path of File to open**.
3. Double-click on a row in **Additional Properties** to change settings. You can use the PatNum (enter 0) or the ChartNum (enter 1) as the patient ID.
4. Set up a clickable bridge button.
   1. Under **Add a button to these toolbars**, highlight where to display the button.
   2. Enter the **Text on button**.
   3. (Optional) Import an image to show on the button (22 x 22 pixels).
5. If using clinics, click **Hide Button for Clinics**. Select which clinics the button should display on.
6. Click OK.

**OrthoPlex Bridge**

In the **Main Menu** (592), click Setup, **Program Links** (934). Double-click on **OrthoPlex from Dentsply GAC**.
OrthoPlex is an ortho imaging program. Website: www.gacorthoplex.com.

To enable the bridge:
1. Check the Enabled box.
2. Verify the Path of file to open.
3. Set up a clickable bridge button.
   1. Under Add a button to these toolbars, highlight where to display the button.
   2. Enter the Text on button.
   3. (Optional) Import an image to show on the button (22 x 22 pixels).
4. If using clinics, click Hide Button for Clinics. Select which clinics the button should display on.
5. Click OK.

Oryx Bridge
In Program Links (934), double-click on Oryx from oryxdentalsoftware.com.
Oryx offers a clinical module. Website: https://oryxdentalsoftware.com/.

To enable the bridge:
1. Check the Enabled box.
2. Double-click on Additional Properties to change settings.
   o Client URL: Enter the unique URL Oryx has assigned to the office.
3. Setup up a clickable bridge button.
   1. Under Add a button to these toolbars, highlight where to display the button.
   2. Enter the Text on button.
   3. (Optional) Import an image to show on the button (22 x 22 pixels).
4. If using clinics, click Hide Button for Clinics. Select which clinics the button should display on.
5. Click OK.

When enabled, a dropdown menu will appear next the Oryx button. Click User Settings from the dropdown to enter a username and password.
Click **OK** to save.

**PANDA Perio Bridge**

In the **Main Menu** (592), click Setup, **Program Links** (934), PandaPerio.

Note: In order to successfully bridge to PandaPerio, PandaLauncher is required.
PANDA Perio is periodontal charting software. Website: https://www.pandaperio.com/.

To enable the bridge:
1. Check the Enabled box.
2. Double-click on Additional Properties to change settings. You can use the PatNum (enter 0) or ChartNum (enter 1) as the patient ID.
3. Set up a clickable bridge button.
   1. Under Add a button to these toolbars, highlight where to display the button.
   2. Enter the Text on button.
   3. (Optional) Import an image to show on the button (22 x 22 pixels).
4. If using clinics, click Hide Button for Clinics. Select which clinics the button should display on.
5. Click OK.

Technical Details
This bridge passes the patient's Patient ID, First Name, Last Name, Birthdate, SSN, Home Phone Number, and Work Phone Number. If there is a referral attached and that referral is flagged as Is Doctor then we will also pass the Referring Providers referralnum, First Name, Last Name, Address, and Phone Number

If the patient is a patient clone, the bridge will transfer the non-clone patient information.

If users wish to write to an ini file, use the PANDA Perio (advanced) Bridge (1037) instead.

Owandy Bridge
In the MainMenu(592), click Setup, Program Links(934). Double-click on QuickVision from owandy.com.
Owandy is an imaging software. Website: [www.owandy.com](http://www.owandy.com).

To enable the bridge:
1. Check the **Enabled** box.
2. Verify the **Path of file to open**.
3. Double click on **Additional Properties** to change settings. You can use the PatNum (enter 0) or ChartNum (enter 1) as the patient ID.
4. Set up a clickable bridge button.
   1. Under **Add a button to these toolbars**, highlight where to display the button.
   2. Enter the **Text on button**.
   3. (Optional) Import an image to show on the button (22 x 22 pixels).
4. Click OK.

**Technical Details**
This bridge launches Quick Vision using command line arguments, then passes some data to Quick Vision using Windows API calls. Prior to version 6.7, it uses the hard-coded value of **C /LINK** for the command line. Starting in version 6.7, it uses the command line argument entered in the box above. Open Dental passes the patient PatNum, last name, and first name to Quick Vision. Owandy must be open when you click the bridge button, or the patient will not load in Owandy.
PANDA Perio (advanced) Bridge

In the **Main Menu** (592), click Setup, **Program Links** (934), Panda Perio (advanced) from www.pandaperio.com.

PANDA Perio is periodontal charting software. Website: [https://www.pandaperio.com/](https://www.pandaperio.com/).

Note: In order to successfully bridge to PandaPerio, PandaLauncher is required.

To enable the bridge:

1. Check the **Enabled** box.
2. Verify the **Path of file to open** is correct.
3. Double-click on **Additional Properties** to change settings. You can use the PatNum (enter 0) or ChartNum (enter 1) as the patient ID.
4. Set up a clickable bridge button.
   - Under **Add a button to these toolbars**, highlight where to display the button.
   - Enter the **Text on button**.
   - (Optional) Import an image to show on the button (22 x 22 pixels).
4. If using clinics, click **Hide Button for Clinics**. Select which clinics the button should display on.
5. Click OK.
Technical Details
The only major difference between Panda Perio (advanced) and the PANDA Perio Bridge (1034) is that the advanced bridge writes to an ini file. Users can use either bridge.

The following fields are passed to Panda Perio (advanced) using the ini file:
- Patient ID
- Preferred Name
- Provider Name
- Guarantor Information
- Guarantor Account Number (uses Patnum)
- Referral Information (if referral is marked as 'Is Doctor')

Patient Gallery Bridge
In the MainMenu (592), click Setup, Program Links (934). Double-click on ImageFX from scican.com.

Patient Gallery is an imaging system. Also known as ImageFX. Website: www.patientgallery.com.
To enable the bridge:
1. Check the Enabled box.
2. Verify the Path of file to open.
3. Double-click on Additional Properties to change settings. You can use the PatNum (enter 0) or ChartNum (enter 1) as the patient ID.
4. Set up a clickable bridge button.
   1. Under Add a button to these toolbars, highlight where to display the button.
   2. Enter the Text on button.
   3. (Optional) Import an image to show on the button (22 x 22 pixels).
4. If using clinics, click Hide Button for Clinics. Select which clinics the button should display on.
5. Click OK.

Technical Details
The following information is passed to Patient Gallery using command line parameters during a bridge attempt: PatNum or ChartNumber, first name, last name, SSN, and date of birth. Any semicolons present in any of these fields will be removed before sending to Patient Gallery.

Patterson Imaging Bridge
In the Main Menu(592), click Setup, Program Links(934). Double-click on Patterson Imaging from Patterson Dental Supply Inc.
Patterson is an imaging software. Website: [www.pattersondental.com](http://www.pattersondental.com). This bridge only works with Patterson Imaging version 15 or newer.

Note: Patterson appears to have stopped selling their standalone imaging software (Patterson Imaging) as a product that can be used by dentists transitioning from Patterson Eaglesoft Digital Integration to other Practice Management software, like Open Dental. *See details below.

To enable the bridge:
1. Check the **Enabled** box.
2. Verify the **Path of file to open**.
3. Double-click on **Additional Properties** to change settings. Enter the **System path to Patterson Imaging ini**.
4. Set up a clickable bridge button.
   1. Under **Add a button to these toolbars**, highlight where to display the button.
   2. Enter the **Text on button**.
   3. (Optional) Import an image to show on the button (22 x 22 pixels).
5. If using clinics, click **Hide Button for Clinics**. Select which clinics the button should display on.
6. Click **OK**.

**Technical Details**
- The bridge matches patients based on SSN. If SSN is not present, then it matches on FirstName, LastName, BirthDate.
- If no patient is found matching those criteria, then it creates a new patient in Patterson Imaging.
- Before version 12.2.6, the patient middle initial and preferred name were sent when bridging. This was sometimes a problem because, if the middle initial or preferred name were later changed in Open Dental, then Patterson would
interpret this as a new patient the next time the bridge was used. Patterson would then create a new patient. So we no longer send this information.

- The Path of file to open can vary depending on where the exe is stored on your computer. It may be C:\Patterson Imaging\Shared Files\Imaging.exe

*RE: Patterson Imaging:

We have posted information about Patterson Imaging availability because there may be fewer options for dentists moving from Patterson Eaglesoft with integrated imaging. We want our customers to know this before leaving Patterson Eaglesoft, as they may need to switch to another imaging solution if they do so.

As of 01/22/2018, we have been told that Apteryx, XDR, and Sirona are capable of converting the Patterson Eaglesoft Digital Integration x-rays to their digital software for a fee.

On 3/8/2017, a Patterson representative from the Patterson Technology Center told Open Dental that new Patterson Imaging licenses are no longer available for sale from Patterson and that this had been true since 2/17/2017. We contacted Patterson because multiple customers (Open Dental customers in common with Patterson) called us and told us Patterson was telling them that switching from Patterson Eaglesoft Practice Management software to Open Dental would mean they would not be able to access the images through a new Patterson Imaging installation. We were further told by Patterson that dentists may purchase an existing Patterson Imaging license from another dentist, but even then, Patterson will no longer assist in pointing Patterson Imaging at a database created with Patterson Eaglesoft Digital Integration.

If you have additional or new information, please let us know. If you believe that it is possible to get a new license for Patterson Imaging, please let us know so that we can advise our customers how to do so.

PaySimple Setup

In Program Links (934), double-click PaySimple from paysimple.com.

PaySimple Setup

Alternatively, in the Payment (153) window, right-click PaySimple and select Settings.

See Credit Cards (166), PaySimple (186).
Set up PaySimple to process credit/debit card transactions or ACH payments, direct debit payments to a patient's checking or savings account.

1. Check the Enabled box.
2. Set the default Payment Type for PaySimple transactions. Customize options in Definitions: Payment Types (879). To select a different type for CC Recurring Charges (1430) (credit card transactions), see Account Module Preferences (693), Payment type for recurring charges. ACH recurring charges will use the payment type selected here.
3. Enter the Username and Key supplied by PaySimple.
4. Prevent saving new cards: Determines whether new payment information can be stored.
   o Uncheck: Allow users to process or save new payment information to the patient's account.
   o Check: Prevent users from processing or saving new payment information.
5. Click OK.

Setup for Clinics
Set up PaySimple to process credit/debit card transactions or ACH payments, direct debit payments to a patient's checking or savings account, with Clinics (1505) in order to use different PaySimple login credentials for each clinic in a single database.

1. Open the PaySimple Setup window. There are two options:
   o In the Main Menu (592), click Setup, Program Links (934), PaySimple from paysimple.com.
   o On the Payment (153) window, right-click PaySimple and select Settings.
2. Check Enabled (affects all clinics) to enable PaySimple for all clinics. Unchecking disables PaySimple for all clinics. If the currently logged on user is restricted by clinic, only the clinic they have access to will show in the Clinic dropdown and they will not be allowed to uncheck the Enabled box.
3. Clinic Payment Settings: Set the payment settings for the Headquarters first.
   o Select Headquarters as the clinic.
   o Select the default payment type for PaySimple transactions. Customize options in Definitions: Payment Types (879)
   o Enter the Username and Key supplied by PaySimple.
   o Prevent saving new cards: Uncheck to allow users to process new transactions or save new payment information to a patient's account. Check to prevent users from processing new transactions or saving new payment information.
4. Enter payment settings for each clinic. Headquarters settings will be used if clinic-specific changes are not made. For clinics that will not use PaySimple, select the clinic, then clear out the username and key. When the clinic is attached to a payment, the PaySimple button will not be visible.
5. Click OK to save settings.

See Credit Cards (166), PaySimple (186).
To set whether or not new credit/debit cards and bank information is saved to a patient's account after each transaction, see Account Module Preferences, *Automatically store credit card tokens.*

**PDMP Illinois**

In the **Main Menu**(592), click Setup, **Program Links**(934), **PDMP**.

The PDMP (Prescription Drug Monitoring Program) bridge is for Illinois users only.

The following must be set before using the PDMP bridge:
- **Providers**(1255) must have a First Name, Last Name, DEA Number, and National Provider ID entered.
- **Patients**(62) must have a First Name, Last Name, Birthdate, and Gender entered.

To enable the bridge:
1. Check the **Enabled** box.
2. Double-Click into each of the **Additional Properties** to enter login credentials. These are issued by Logicoy and are required.
   - Illinois PDMP FacilityID.
1. Under **Add a button to these toolbars**, highlight where to display the button.
2. Change the **Text on button** if desired.
3. (Optional) Import an image to show on the button (22 x 22 pixels).
4. If using clinics, click **Hide Button for Clinics**. Select which clinics the button should display on.
5. Click OK.

---

**PerioPal Bridge**

In the **Main Menu**(592), click **Setup, Program Links**(934). Double-click on **PerioPal** in the list.

---

PerioPal is voice activated software for periodontal examinations. The PerioPal website is no longer available.

To enable the bridge:
1. Check the **Enabled** box.
2. Verify the **Path of file to open**.
3. Set up a clickable bridge button.
   1. Under **Add a button to these toolbars**, highlight where to display the button.
2. Enter the **Text on button**.
3. (Optional) Import an image to show on the button (22 x 22 pixels).
4. If using clinics, click **Hide Button for Clinics**. Select which clinics the button should display on.
5. Click OK.

**Technical Details**
The bridge uses a command line as follows:

```
[Application Path]/PerioPal "PtChart;PtName;PtBday;PtMedAlert;"
```

Where:

- **[Application Path]** Usually = `C:\Program Files\PerioPal\`
- **Pt Chart** = AlphaNumeric Chart number from the Office Management System
- **PtName** = Patients Last, First Middle Init
- **PtBday** is the Patient Birthdate in any Microsoft Access compatible date format
- **Pt MedAlert** is a Y or N.

Before version 6.7.16, there was a bug where the trailing semicolon was missing.

If the bridge is not working, then one option is to construct a shortcut that duplicates the bridge. Like this:

The screenshot doesn't show the full text of the Target box:

```
C:\Program Files\PerioPal\PerioPal.exe "23;Smith;Bob;3/25/75;N;"
```
Planmeca Bridge

In the MainMenu, click Setup, Program Links. Double-click on Dimaxis from Planmeca.

Planmeca is imaging software. It is also known as Dimaxis or Romexis. Website: www.planmeca.com.

To enable the bridge:
1. Check the Enabled box.
2. Verify the Path of file to open.
3. Double-click on a row in Additional Properties to change settings.
   1. You can use the PatNum (enter 0) or ChartNum (enter 1) as the patient ID.
   2. Enter Birthdate format. Use (dd/MM/yyyy) or (MM/dd/yyyy).
3. Set up a clickable bridge button.
   1. Under Add a button to these toolbars, highlight where to display the button.
   2. Enter the Text on button.
   3. (Optional) Import an image to show on the button (22 x 22 pixels).
4. If using clinics, click Hide Button for Clinics. Select which clinics the button should display on.
5. Click OK.
**Technical Data**

Open Dental sends commands to Planmeca via the command line. This is made possible by a program called DxStart which Planmeca provides for this purpose. The syntax looks like this:

```
DxStart.exe "PatientID" "FamilyName" "FirstName" "BirthDate" &lt;"Doctor"&gt;
```

All the fields are in quotation marks because they may include blanks. Normally Dimaxis asks the password to the database at startup. This can be prevented by adding the following line into the [ODBC] section of the Dimaxis.ini file (in the Windows directory): PWD=dixi

If the patient that was passed in the DxStart command line exists in the Dimaxis database, the patient information in the database will be updated if any of the passed fields differs from the values in the database.

The one disadvantage of this bridge is that it can only handle Latin characters, and not other character sets such as Greek. In order to support other character sets, we would have to implement the Windows DLL bridging interface, PmBridge, available for Dimaxis.

**Romexis**

DxStart.exe was designed for Dimaxis, but it will also work with Romexis. When Romexis is first installed, perform a custom installation and make sure the PmBridge option is enabled. This should result in the installation of DxStart.exe. If Romexis is already installed and the PmBridge option was not enabled, then call Planmeca support for help reinstalling Romexis with the PmBridge option enabled.

**Podium Bridge**

In the *Main Menu* (592), click Setup, *Program Links* (934). Double-click on *Podium*.

Podium allows users to automatically send review invitations to new and recurring patients. Podium uses your practice’s appointment schedule to send review invitations by text message to existing patients at increments of your choosing.
Podium accesses your database of patient phone numbers automatically, so you will never have to worry about manually sending out review invites.

To sign up for Podium and begin using their services, visit https://try.podium.com/opendental/. You must be signed up for Podium to use the bridge in Open Dental. Once set up, click the Podium button in Standard Reports (1278) to launch your account.

Note: Exceptions thrown by Podium can be found in “PathToOpenDental”\Logger\Podium.

To enable the bridge:
1. Check the Enabled box.
2. Enter your Computer name or IP (required).
3. Enter the API Token (required) and Location ID (required) supplied by Podium.
4. To use OpenDentalService, check Use service to send invitations. If not, the computer that will send Podium review invitations needs to have Open Dental running at all times. To install OpenDentalService see Service Manager (1412).
5. To show Podium comlogs in the Chart module, check Show comlogs in the chart. Uncheck to hide comlogs from the patient chart. This box is checked by default.
6. Choose the clinic that will be associated with the invite. The Location ID will change depending on clinic.
7. Set Trigger Rules. After the trigger action (e.g. an appointment is set complete), the invitation will be sent according to the rules.
8. Select trigger options for existing and new patients.
   o Set complete: Send an invitation after an appointment is set complete.
   o Time Arrived: Send an invitation after a patient is marked arrived.
   o Time Dismissed: Send an invitation after a patient is marked dismissed.

Note: If a patient declines review invitations be sent via text message, set their Text OK status in the Edit Patient Information (62) to No. Review invitations will still be sent via email.

Practice by Numbers Bridge
In the MainMenu (592), click Setup, Program Links (934). Double-click on Practice by Numbers.
Practice by Numbers integrates your practice management and accounting data and creates custom dashboards and reports.

To sign up for Practice by Numbers and begin using their services, visit their website: Practice by Numbers. You must be signed up for Practice by Numbers to use the bridge in Open Dental. Once set up and the bridge is enabled, click the Practice by Numbers button in Reports to launch your account.

To enable the bridge:
1. Check the **Enabled** box.
2. Enter the **Text on button**.
3. Set up a clickable bridge button.
   1. Under **Add a button to these toolbars**, highlight where to display the button.

   Leave blank to show this button in the Reports window only.
2. Enter the **Text on button**.
3. (Optional) Import an image to show on the button (22 x 22 pixels).
4. If using clinics, click **Hide Button for Clinics**. Select which clinics the button should display on.
5. Click OK.

To remove the Practice by Numbers button from the Reports window, uncheck Enabled, then check Hide Unused Button.
PracticeWeb Reports Bridge
In the **Main Menu**(592), click Setup, **Program Links**(934). Double-click on PracticeWeb Reports.

1. Check the **Enabled** box.
2. Verify the **Path of file to open**.
3. Click OK.

Website: [www.practice-web.com](http://www.practice-web.com).

PreXion Bridge
In the **Main Menu**(592), click Setup, **Program Links**(934). Click **Add** to create a custom bridge.
PreXion is imaging software. Website: [www.prexion.com](http://www.prexion.com).

To enable the bridge:
1. Enter the **Description** as PreXion.
2. Check the **Enabled** box.
3. Enter the **Path of file to open** as shown below.
4. Enter the **Optional command line arguments** as shown below.
5. Set up a clickable bridge button.
   1. Under **Add a button to these toolbars**, highlight where to display the button.
   2. Enter the **Text on button** as PreXion.
   3. (Optional) Import an image to show on the button (22 x 22 pixels).
4. If using clinics, click **Hide Button for Clinics**. Select which clinics the button should display on.
5. Click OK.

**Technical Details**
The command line arguments will be similar to this:

```
-l shared -p shared -pid [ChartNumber] server 1200
```

```
-l username -p password -pid [ChartNumber] servername 1200
```

In the first example, the username and password are both shared. Servername is the name of the PreXion server. 1200 refers to the port.
You must use ChartNumber instead of PatNum because the ID used in PreXion is different than the ID used in Open Dental. For each new patient, you will enter them into Open Dental, and then you will again manually enter them into PreXion. PreXion will assign an ID for the new patient, and you must manually enter this ID into the ChartNumber field in the Open Dental Patient Edit window. Once the ChartNumber is entered, the bridge will work for viewing an existing patient's images.

**Progeny Bridge**

In the [Main Menu](592), click Setup, **Program Links**(934). Double-click on **Progeny** from [www.progenydental.com](http://www.progenydental.com).

![Progeny Bridge Setup](image)

Progeny is an imaging software. Website: [www.progenydental.com](http://www.progenydental.com).

To enable the bridge:

1. Check the **Enabled** box.
2. Verify the **Path of file to open**.
3. Double-click on **Additional Properties** to change settings. You can use the PatNum (enter 0) or ChartNum (enter 1) as the patient ID.
4. Set up a clickable bridge button.
   1. Under **Add a button to these toolbars**, highlight where to display the button.
   2. Enter the **Text on button**.
   3. (Optional) Import an image to show on the button (22 x 22 pixels).
4. If using clinics, click **Hide Button for Clinics**. Select which clinics the button should display on.
5. Click OK.

**Technical Details**
The following patient information is sent to Progeny when the bridge button is pressed in OD: first name, last name and identifier (either PatientNum or ChartNum depending on the setting. Enter 0 to use PatientNum, or 1 to use ChartNum). Patients are loaded in Progeny based on the identifier passed in from Open Dental. Progeny doesn't accept two word last names.

Date of Birth is required to be entered for patients for bridge to launch.

Receive an error message in Progeny: No Patient Selected. If you close Progeny, then launch the bridge in Open Dental, this error message may display depending on how long Progeny takes to load. Eventually, the patient does load.
To avoid this message, leave Progeny running in the background.

When I launch the Progeny program link, more than one instance of Progeny is created.
Call Progeny support to get help upgrading Progeny to version 1.10 or later.

**PT Dental Bridge**
In the [MainMenu](592), click Setup, [Program Links](934). Double click on [PT Dental](.)
PT Dental offers paperless technologies. Website: www.gopaperlessnow.com. There is a functional 2-way bridge to handle Registration Forms.

To enable the bridge for both PT Dental buttons.
1. In the list of Program Links, double click on both PT Dental and PT Dental Update.
2. Check the Enabled box.
3. If using clinics, click Hide Button for Clinics. Select which clinics the button should display on.
4. Click OK.

You will now have buttons in your Family module labeled PT Dental and PT Dental Update.
Using PT Dental
You will always create the patient first in Open Dental. This patient will now have an automatically assigned PatNum. Click the PT Dental button to send the patient data to PT Dental. Now, both programs will have the same patient data. You will also use the PT Dental button any time you wish to open the patient in PT Dental. If the patient fills out a form in PT Dental, whether online or in the office, certain patient data may need to be updated. This includes demographics, insurance, referral, and med alerts. You can use the button in PT Dental to send this information to OD. You will see a box come up in OD informing you that the transfer was successful. See the newly created Commlog entry for details that couldn't be automatically transferred, such as insurance and referral. If you ever make changes in OD which you wish to send to PT Dental, use the PT Update button in the OD toolbar.

Technical Details
The data transfer involves about 6 different files, all in C:\PTUSI. This path is hard coded. Both PT Dental and OD know which filenames to use when passing data back and forth. They also know how to watch for new files so that there is no delay. The files involved get deleted immediately after they are consumed. The OD PatNum is used as the primary key in all data transfers. So any field can be changed, including last name, first name, and birthdate without confusing the synchronization functionality. Patients may use PT Dental to fill out forms in the office or online. When they do it online, PT Dental is responsible for synchronizing the data between its website and each locally installed PT Dental program. From there, the data is transferred to OD. PT Dental will also provide a scripting program that simulates mouse clicks and keystrokes to interact with Open Dental.

The PT Dental script attempts to open the Open Dental Referrals window for the patient. But there is no button in the user interface. So Open Dental allows a key shortcut of Ctrl-Alt-R. The script then uses this keystroke to open the Referrals window. Unfortunately, the Ctrl-Alt-R combination doesn't work on some computers. Nobody knows why. So in version
6.4.21, we also added Ctrl-X as a keystroke that will open the Referrals window. The PT Dental script should be using the newer keystroke.

**DentalTek Rapid Call Bridge**

DentalTek offers a comprehensive suite of services including cloud hosting, VOIP phones integrated with Open Dental, discounts on supplies and labs, and patient communications.

In the **MainMenu** (592), click Setup, **Program Links** (934). Double-click on **Rapid Call**.

Rapid Call is a DentalTek feature that automatically deploys a pre-recorded message when customer voicemail picks up. Staff can then move on to dial another call. Rapid Call is included when you sign up for DentalTek, but you can purchase Rapid Call on its own. For more information, visit: [DentalTek Calling](#).

There a few steps to follow before Rapid Call can be used.
1. Sign up for [DentalTek](#).
2. Set up the [DentalTekBridge](970).
3. Enable the Rapid Call bridge:
   1. Do not enter Text on button or Add a button to these Toolbars. These features are non-functional for this bridge.
   2. Check the **Enabled** box.
   3. If using clinics, click **Hide Button for Clinics**. Select which clinics the button should display on.
4. Click OK.

When the steps are completed, begin using the Rapid Call feature. Click the Rapid Call button in the Appointments module to launch the application.

To remove the Rapid Call button from the Appointment Module, uncheck Enabled, then check Hide Unused Button.

RayMage Bridge
In the Main Menu (592), click Setup, Program Links (934). Double-click on RayMage from www.cefla.com.

RayMage is imaging software. Website: www.cefla.com/en.

To enable the bridge:
1. Check the Enabled box.
2. Verify the Path of file to open.
3. Double click on Additional Properties to change settings. You can use the PatNum (enter 0) or ChartNum (enter 1) as the patient ID.
4. Set up a clickable bridge button.
   1. Under Add a button to these toolbars, highlight where to display the button.
   2. Enter the Text on button.
3. (Optional) Import an image to show on the button (22 x 22 pixels).
4. If using clinics, click **Hide Button for Clinics**. Select which clinics the button should display on.
5. Click OK.

**Technical Details**
If the patient ID already exists in RayMage, then the corresponding patient folder is opened. If the patient ID does not exist in RayMage, then a new patient folder is created and opened. When a patient ID already exists in RayMage and the patient name passed in does not match (for example when a patient name is updated), then a message box will display in RayMage asking the user if they want to change the patient name and the patient folder corresponding to the existing ID is opened.

Open Dental launches RayMage with the following command line arguments:
```
/PATID "123456" /NAME "John" /SURNAME "Smith"
```

The name and surname arguments will be the patient's first and last name with all spaces and quotes removed from them.

**Scanora Bridge**
In the **Main Menu**(592), click Setup, **Program Links**(934). Double-click on **Scanora from www.soredex.com**.
Scanora is a cone beam tomography and optional 2D panoramic imaging system in one. Website: https://www.kavo.com/en-us/?lang=en-us.

To enable the bridge:
1. Check the Enabled box.
2. Verify the Path of file to open.
3. Double-click on a row in Additional Properties to change settings.
   1. You can use the PatNum (enter 0) or ChartNum (enter 1) as the patient ID.
   2. Set Import.ini path for the Scanora.ini file.
3. Set up a clickable bridge button.
   1. Under Add a button to these toolbars, highlight where to display the button.
   2. Enter the Text on button.
   3. (Optional) Import an image to show on the button (22 x 22 pixels).
4. If using clinics, click Hide Button for Clinics. Select which clinics the button should display on.
5. Click OK.

Technical Details
This is an example of what your ini should look like:

[PracticeManagementInterface]
CLEAR_PRACTICE_MANAGEMENT_AUTOMATICALLY = 1
USE_PRACTICE_MANAGEMENT = 1
PATID = 443672
PATLNAME = Test1
PATMNAME =
PATFNAME = Scanora
PATSOCSEC = 123456789
PATBD = 1980-10-20
PROVIDER1 = Jessica Castaneda, FNP
PROVIDER2 = doc Testnew
ADDRESS1 = 1234thst
ADDRESS2 =
CITY = Albany
STATE = OR
ZIP = 97321
HOMEPHONE = 5415222222
WORKPHONE = 5412222222
EMAIL1 = abc@gmail.com

Your ini file should be in the ANSI encoding file format with a leading blank line.
Schick CDR Dicom Bridge

In the Main Menu(592), click Setup, Program Links(934). Double-click on Schick from www.schicktech.com.

Schick is a digital imaging software. Website: www.schickbysirona.com.

To enable the bridge:
1. Check the Enabled box.
2. Double-click on a row in Additional Properties.
   1. You can use the PatNum (enter 0) or ChartNum (enter 1) as the patient ID.
   2. Schick Version 4 or 5: Enter the version of Schick you are using. The default is version 5. Version 4 applies to any version prior to version 5.
3. Set up a clickable bridge button.
   1. Under Add a button to these toolbars, highlight where to display the button.
   2. Enter the Text on button.
   3. (Optional) Import an image to show on the button (22 x 22 pixels).
4. If using clinics, click Hide Button for Clinics. Select which clinics the button should display on.
5. Click OK.
**Technical Details**

Open Dental passes the LN (last name), FN (first name), and PatNum/ChartNum to Schick.

Within Schick, make sure that it is set to use bridge mode.

Schick versions older than v3.5 will not reuse the exam window.

For Windows 10, the minimum requirement is CDR DICOM 5. See [https://www.schickbysirona.com/items.php?itemid=17990](https://www.schickbysirona.com/items.php?itemid=17990)

You may also use the Apteryx Data Grabber instead of our built-in bridge if you wish: [https://apteryx.com/product/datagrabber/](https://apteryx.com/product/datagrabber/).

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**Sirona Sidexis Bridge**

In the [Main Menu](#) (592), click Setup, [Program Links](#) (934). Double-click on **Sirona Sidexis from www.sirona.com**.

Sirona SIDEXIS XG is an imaging software. Website: [www.sidexis.com](http://www.sidexis.com).

Note: Sidexis 4 is different than Sidexis XG. To use the latest update for Sidexis 4, change the path of file to open to the correct exe (e.g. `C:\Program Files\Sirona\SIDEXIS4\XG\sidexis.exe`).
To enable the bridge:
1. Check the **Enabled** box.
2. Verify the **Path of file to open**.
3. Double-click on **Additional Properties** to change settings. You can use the PatNum (enter 0) or ChartNum (enter 1) as the patient ID.
4. Set up a clickable bridge button.
   1. Under **Add a button to these toolbars**, highlight where to display the button.
   2. Enter the **Text on button**.
   3. (Optional) Import an image to show on the button (22 x 22 pixels).
4. If using clinics, click **Hide Button for Clinics**. Select which clinics the button should display on.
5. Click OK.

**Technical Details**

Dates are always sent to Sirona in European format "dd.mm.yyyy", as required by Sirona. In Canada and in other countries, if there is a mixture of computers in the office with different Windows Region and Language Settings, this may cause duplicate patients to be created by Sirona when comparing birthdates. This seems to especially be a problem if patients were manually entered into Sirona.

A file called sifiledb.ini must exist in the sidexis folder. If the file is not found, then trying to use the bridge will result in an error message about that file.

Open Dental reads the ini file, FromStation0 | File to determine location of comm file (sendBox) (siomin.sdx). For example, this File location indicates only one sendBox on the entire network:

```
[FromStation0]
File=F:\PDATA\siomin.sdx
```

Open Dental then sets OfficeManagement | OffManConnected = 1 to make sidexis ready to accept a message. For example:

```
[OfficeManagement]
OffManConnected=1
```

Open Dental then adds a "U" section to the comm file (siomin.sdx), signifying Update patient in sidexis. The entire "U" section gets ignored by Sidexis if this is a new patient. Open Dental leaves the "initial patient id" blank, causing the patient id used in Sidexis to get updated to the PatNum or ChartNumber used in Open Dental.

Open Dental then adds a "N" section to the comm file. N signifies create New patient in sidexis. If patient already exists, then it simply updates any old data.

Open Dental then adds an "A" section to the comm file. A signifies Autoselect patient.

In each of the three sections discussed above, the full name and birthdate are included, and Sidexis seems to use name and birthdate to identify patients.

Open Dental then launches Sidexis.exe.

A troubleshooting step would be to get a copy of the ini file before Sidexis is launched, possibly by changing the program link to launch a dummy file instead of Sidexis.exe. This would prevent consumption of the ini file.

**SMARTDent Bridge**

In the **Main Menu** (592), click Setup, **Program Links** (934). Double-click on **SMARTDent from www.raymedical.com**.
To enable the bridge:
1. Check the Enabled box.
2. Verify the Path of file to open.
3. Double-click on Additional Properties to change settings. You can use the PatNum (enter 0) or ChartNum (enter 1) as the patient ID.
4. Set up a clickable bridge button.
   1. Under Add a button to these toolbars, highlight where to display the button.
   2. Enter the Text on button.
   3. (Optional) Import an image to show on the button (22 x 22 pixels).
4. If using clinics, click Hide Button for Clinics. Select which clinics the button should display on.
5. Click OK.

**Technical Details**
SMARTDent will select the patient by matching the Patient/Chart Number and Patient Name (FName + LName) to the patient that is selected in Open Dental.

Solutionreach/Smile Reminder Bridge
Smile Reminder has rebranded and is now Solutionreach. Solutionreach is one of the companies that provides Communication Supplemental Services to Open Dental users as well as to users of other dental software products.

They have implemented their own bridge to Open Dental. They will install a program on your server that grabs data from the Open Dental database as needed and uploads it to their server. This bridge has been functional for many years, and a number of our customers use it.

Sopro Bridge

In the MainMenu, click Setup, Program Links. Double-click on Sopro by Acteon www.acteongroup.com.

Sopro by Acteon is imaging software. Website: www.acteongroup.com.

To enable the bridge:
1. Check the Enabled box.
2. Verify the Path of file to open.
3. Double-click on Additional Properties to change settings. You can use the PatNum (enter 0) or ChartNum (enter 1) as the patient ID.
4. Set up a clickable bridge button.
   1. Under Add a button to these toolbars, highlight where to display the button.
2. Enter the **Text on button**.

3. (Optional) Import an image to show on the button (22 x 22 pixels).

4. If using clinics, click **Hide Button for Clinics**. Select which clinics the button should display on.

5. Click OK.

**Technical Details**

You may need to configure Sopro to accept bridge arguments. Sopro Image Menu File, Setup, Main tab, Link section, select Type 90.

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**Spear Education**

*Spear* (934) Education is a practice solution consulting company that provides education, coaching, and analytics to improve dental practices at a business level. Spear’s real-time analytics run queries in Open Dental which can cause slowness.

There are two options to help counter slowness issues caused by Spear.

1. Set up a reporting server utilizing one-way replication. See [One-Way Replication Setup](#).
2. Convert tables from MyISAM to InnoDB. See [MySQL InnoDB](#).

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**SpeedVision Bridge**

Lightyear SpeedVision is no longer sold.

In the [Main Menu](#592), click Setup, [Program-Links](#934). Double click on **SpeedVision** from [www.lightyeardirect.com](http://www.lightyeardirect.com).
To enable the bridge:
1. Check the **Enabled** box.
2. Verify the **Path of file to open**.
3. Double-click on **Additional Properties** to change settings. You can use the PatNum (enter 0) or ChartNum (enter 1) as the patient ID.
4. Set up a clickable bridge button.
   1. Under **Add a button to these toolbars**, highlight where to display the button.
   2. Enter the **Text on button**.
   3. (Optional) Import an image to show on the button (22 x 22 pixels).
5. If using clinics, click **Hide Button for Clinics**. Select which clinics the button should display on.
6. Click **OK**.

---

**Suni**

Suni offers sensors and the imaging software Prof Suni and Dr. Suni. See the [SuniWebsite](#). We also have **Bridges** (934) to other imaging software that works with Suni sensors. See [Interoperability with Other Software](#)

We provide limited support for direct connection to Suni sensors. The 1200, 1200C, 1600, 1800 series are supported. #1 hi res are the only supported sensors. Currently, there is only a 4BW mount used for capturing. See Scanning/Imaging Defaults(741) to set the Suni hardware options. Because of the limited mounts and lack of a ruler, the support for Suni is marginal, and very likely not ready for prime time. But it is functional.

To capture an image, click Capture in the Images module.

**Setup a Suni Sensor**

To setup a Suni sensor for use with Open Dental directly copy the contents of the Suni CD that came with your sensor into the C:\Program Files\Open Dental\Suni\ directory. If you have more than one sensor, you must be sure to copy the contents of the CD that came with the sensor hooked up to the computer in question. You should also ensure that the drivers for your Suni sensor are up to date in the Windows hardware manager. Check these before you try anything else. It may help if you reset your Suni hardware. You can do that by unplugging the USB connection from the back of the computer and unplugging the connection to the wall socket (if there is one). Leave the device disconnected for at least 1 minute, then reconnect and try to capture again.

Open Dental does not currently support more than one sensor per workstation.

Also see this document: SuniSensorDocument.pdf

1/23/2014: Suni sensor models 1200, 1600, and 1800 are not compatible with Windows 7, Windows 8, or Windows 8.1 because there are no drivers available for the 32 or 64 bit versions. http://suni.com/usa/support/intraoral_imaging.aspx

**TigerView Bridge**

In the MainMenu(592), click Setup, Program Links(934). Double-click on TigerView from www.televere.com.
TigerView is an imaging software. Website: [www.televeresystems.com](http://www.televeresystems.com).

Visix for ScanX is a rebranded version of TigerView, so use the TigerView bridge to set up the Visix software. ScanX also has a self-named intraoral camera, which does not use this bridge. This bridge is for Visix and TigerView software only.

To enable the bridge:
1. Check the **Enabled** box.
2. Verify the **Path of file to open**.
3. Double-click on a row in **Additional Properties** to change settings.
   1. Set the Tiger1.ini file path. It should always be set to match the default TigerView ini path because TigerView always looks to its default path and will not return patient data if it cannot find the ini file.
   
   **Note:** Certain newer versions of TigerView may require the Tiger1.ini file to be located in the same folder as the Tiger1.exe program file (e.g. C:\tigerview8).  

   2. You can use the PatNum (enter 0) or ChartNum (enter 1) as the patient ID.
   3. Set the EMR folder path if using TigerView EMR.
   4. Set the format for birth dates. It should be set to MM/dd/yy (default) or MM/dd/yyyy (4-digit year).
4. Set up a clickable bridge button.
   1. Under **Add a button to these toolbars**, highlight where to display the button.
   2. Enter the **Text on button**.
   3. (Optional) Import an image to show on the button (22 x 22 pixels).
5. If using clinics, click **Hide Button for Clinics**. Select which clinics the button should display on.
6. Click **OK**.
**Technical Details**

Clicking the Visix/TigerView button will open the patient in the Visix/TigerView software. If the patient doesn't yet exist, it will create a record using the patient's name and PatNum.

As of version 14.2, thumbnails are pulled into Open Dental with the help of TigerView EMR.
1. Run TigerView EMR and set an export path.
2. In Additional Properties on the Program Links window, set the TigerView EMR folder path to the export path.

If set up properly, when Open Dental starts and while it's running, thumbnails will be copied from the TigerView export folder into the patient's OpenDentImages folder. An x-ray Image Category that shows in Chart module will be automatically created in **Definition Setup** (835). Thumbnails will show under the x-ray category in the **Images Module** (480) and there will be an x-ray tab at the bottom of the **Chart Module** (298). If you do not see an x-ray tab, make sure show in Chart module is set in Definitions.

Open Dental writes data to the **Tiger1.ini** file similar to this:

```
[Slave]
LastName=Spander
FirstName=Jeremy
PatientID=1234
PatientSSN=123456789
Gender=Male
DOB=03/21/75
AddrStreetNo=123 Main
AddrCity=
AddrState=OR
AddrZip=97302
PhHome=(503) 363-5432
PhWork=(503) 271-3821
```

Open Dental then launches TigerView. TigerView opens with no splash screen to the designated patient. TigerView deletes the patient information from the ini file.

**When I push the TigerView button to launch TigerView, I see a message in TigerView which informs me that a provider was not specified.**

If there is only one provider within TigerView (ex System Admin), then you can call TigerView support to enable the option to bypass the provider window. Even if you have multiple providers in Open Dental, you will probably only have one provider inside of TigerView, and that provider is usually named System Admin. If you have multiple providers inside of TigerView, see feature request #2295.

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**Trophy Bridge**

In the **MainMenu** (592), click Setup, **Program Links** (934). Double-click **Trophy**.
After version 5.0, this is known as Kodak Dental Imaging (KDI). Also use this bridge for some Carestream products.

There are two different Trophy bridges available:
- **Simple**: May be used for new installations of Trophy, but not recommended. It always uses the patient ID (PatNum) as the image folder name.
- **Enhanced**: Recommended for new installations. Required for existing installations of Trophy. For existing installations, the user must type in the name of the folder in the Edit Patient Information window for each patient.

Note: To change patients, you must close Kodak, switch patients in Open Dental, then reopen the bridge.

To enable the bridge:
1. Check the **Enabled** box.
2. Verify the **Path of file to open**.
3. Double click on a row in **Additional Properties** to change settings.
   1. Storage Path: Where images are stored.
   2. Enter 1 to enable Numbered Mode
3. Set up a clickable bridge button.
   1. Under **Add a button to these toolbars**, highlight where to display the button.
   2. Enter the **Text on button**.
   3. (Optional) Import an image to show on the button (22 x 22 pixels).
4. If using clinics, click **Hide Button for Clinics**. Select which clinics the button should display on.
5. Click OK.
**Technical Details**

Storage Path: The storage path might look similar to

```plaintext
\\SERVER\twor
```

```plaintext
F:\tw
```

The storage path must be set to exactly the same value as the database location within Trophy. To change the database location in Trophy, in the main menu click options or preferences and that will open a window with a series of tabs. Inside one of the tabs there will be a place to enter a location for the database. Trophy uses this database path when searching for patients.

**Simple Bridge**

If using the simple bridge, Open Dental always simply uses the Open Dental PatNum to name the Trophy folders. For example, for John Smith, PatNum=123, his images might be found in this folder:

```plaintext
\\SERVER\tw\123
```

**Enhanced Bridge**

If using Fona OrisWin imaging then the enhanced bridge is the correct bridge to use. If using the enhanced bridge, then each patient will have a Trophy Folder path entered in the Patient Edit window. The folder name for one patient might look similar to

```plaintext
G.rvg\G0000001or
\\SERVER\tw\G.rvg\G0000001
```

The bridge makes the following assumptions:
- User has previously used the standalone mode of Trophy.
- The previous program created a text file inside each patient folder. The format of the text file is shown further down.
- The storage path contains a series of A to Z folders named like A.rvg, B.rvg, C.rvg, etc.

**Automation capabilities of the bridge:**
- Searches text files for matching LName, FName, Birthdate.
- If all three match, uses that folder.
- If birthday doesn't match, but there is exactly one match for LName and FName, then it use that folder.
- Otherwise, lets user choose from existing list of folders.
- User can create folder for new patient, which automatically increments the max folder number by one.
- Open Dental does not create new text files. It only makes use of existing text files.

**Example text file:**

Name of file: FILEDATA.txt. Contents:

```plaintext
[Patient file]
NUMERO=W0000022
NOM=WALIA
PRENOM=KUNAL
DATE=19820411
SECU=...-..-....
```
Enhanced Bridge, Numbered Mode

Some installations of Trophy do not use FILEDATA.txt files, and the folders are numbered according to patient ID. The patient folders are grouped into subfolders with similar numbers. If the user has had a conversion from SoftDent to Open Dental, and if the patient ID numbers have been preserved, then many existing patients will already have patient image folders named by their patient numbers.

Automation sequence:
- Searches all subfolders of main image folder, regardless of folder organization.
- If a folder name matches the patient ID, then it assigns that folder to the patient.
- If no folder is found, it creates a folder with the name of the patient ID. It puts it in a subfolder named by the last two digits. Example: 23/123

As an alternative to linking folders on the fly, we provide an image conversion service which links up the folders ahead of time.

Troubleshooting

If the bridge isn't working, you can troubleshoot it by creating a windows shortcut. On your desktop, in a blank area, right click, New, Shortcut. The location / target will be the Trophy program itself. For example, C:\Program Files\Trophy\TW.exe. After creating the shortcut, right click on it and select properties. Edit the target. Add a space after the original target and then -P, then no space, then the full path to a patient folder without any trailing \. Similar to this:

C:\Program Files\Trophy\TW.exe -PF:\tw\G.rvg\G0000001

Click OK to close the properties window. Then, click your shortcut to test. This simulates exactly what Open Dental is doing. If you can't get this to work, then Open Dental won't work either. If you can't get it to work, please contact support for troubleshooting.

But if it does work, you should be able to change the settings in Open Dental to match.

Trojan Bridge

In Program Links(934), double-click on Trojan.
Trojan provides insurance benefit information. The benefit information is stored on a computer in the dental office, and gets frequently updated through the internet. Instead of a direct integration with their database, we have chosen a simpler integration, using an intermediate standalone Trojan program. Website: www.trojanonline.com.

**Using Trojan**

In Trojan:
1. Look up an insurance plan.
2. Click Export Plan at the lower right to export all the plan information to a text file which Open Dental can import.

In Open Dental:
1. On the Insurance Plan(81), click Trojan to fill the insurance plan with the exported data from Trojan.

A copy of the data will be stored.

Each plan is tracked by a TrojanID which shows in the ID box. As long as you leave the TrojanID in the box, the plan will continue to be updated every time Trojan releases a new update. The update to Open Dental is performed after you install your new Trojan data update. Each time you start up Open Dental, it checks for changes in Trojan.

2. To view benefit notes, click Trojan/IAP Note.
Technical Information

- Trojan uses a registry to store the path to your Trojan files. The path to that registry should be `HKEY_LOCAL_MACHINE\SOFTWARE\Trojan`. The registry key values contain `INSTALLDIR`.
- If you are getting a message that says your Trojan has been updated, locate the `ALLPLANS.txt` file in the `INSTALLDIR` path and move the `ALLPLANS.txt` file to a new directory.

Trojan Express Collect

In the **Account Module** (150), click **Trojan** (1072) Collect.
Also see: Troyan Express Collect Bridge

Trojan provides insurance benefit information services as well as a collections service. Trojan Express Collect must be enabled in Program Links(934), for the Trojan Collect button to show.

Before the first window comes up, all patient and guarantor information is validated. The user is notified of missing or incorrect information and must fix it before continuing. Once the window is opened successfully, the user must verify the Delinquency Date and the Amount of debt. The password must only be entered once, and is then retained between sessions.
Tscan Bridge

In the **Main Menu** (592), click Setup, **Program Links** (934). Double-click on Tscan from **www.tekscan.com**.
Tscan is digital imaging software. Website: www.tekscan.com.

To enable the bridge:
1. Check the Enabled box.
2. Verify the Path of file to open.
3. Double click on Additional Properties to change settings. You can use the PatNum (enter 0) or ChartNum (enter 1) as the patient ID.
4. Set up a clickable bridge button.
   1. Under Add a button to these toolbars, highlight where to display the button.
   2. Enter the Text on button.
   3. (Optional) Import an image to show on the button (22 x 22 pixels).
5. If using clinics, click Hide Button for Clinics. Select which clinics the button should display on.
6. Click OK.

**Technical Data**

Patient ID is the key link between OD and Tscan. The Tscan program requires the patient ID to be composed of letters and numbers only. If the Enter 0 to use PatientNum, or 1 to use ChartNum property is set to 1, then any characters that are not letters or numbers will be removed before the bridge is invoked. When the bridge is invoked, Tscan performs a case-insensitive search to locate the existing patient. If a patient ID match is found for an existing patient within the Tscan database, then the found patient is selected in Tscan. If the patient ID is not found, then a new patient is created in Tscan. If Tscan finds the same patient ID and there is discrepancy between first, last or middle names, then a warning message is displayed.
Additionally, the bridge always sends the patient first and last name to Tscan and removes any characters which are not letters or numbers. If a patient middle name has been entered, then the bridge sends the patient middle name and removes any characters which are not letters or numbers. If the patient has a birthdate entered in OD, then the birthdate is sent over to Tscan, otherwise no birthdate is sent. If the patient gender is set to male or female, then the gender information will be sent to Tscan. Otherwise, if the patient gender is set to unknown then the gender is not sent to Tscan.

TSI Setup
In Program Links (934), double-click on Transworld Systems Inc. (TSI).

To begin using the TSI Collections (527) Interface, there are three basic steps:
1. Sign up with TSI and receive your TSI credentials.
2. Set up the TSI program link.
3. Create a collections billing type for TSI accounts.

Step 1: Sign Up for TSI Services See www.tsico.com/alliances/opendental.

Step 2: Set up the TSI Program Link in Open Dental
1. Check the **Enabled** box.

2. **Clinic**: Only visible if clinics is turned on. Use to enter different credentials for each clinic. Click the dropdown to select the clinic, then proceed to steps 4 - 8.

   **Note**: By default, credentials entered for Headquarters will be copied for each clinic. Once an individual clinic credentials is modified to differ from Headquarters, changes to Headquarters settings will no longer affect the clinic's settings.

3. **Services Enabled**: Select the TSI services to enable.
   - **Accelerator**: Gentle payment reminder letters sent to patients on your behalf.
   - **Profit Recovery**: TSI contacts patients on your behalf in a more urgent, yet friendly approach.
   - **Collections**: Urges patients to make payments before they are charged off as bad debt.

4. **SFTP Server Details**: Enter the TSI SFTP server details and login credentials (provided by TSI).
   - **Address**
   - **Port**
   - **Username**
   - **Password**

5. **Client IDs**: Enter your client ID for each enabled service.
   - **Accelerator**: The ID provided to you by TSI for the Accelerator service.
   - **Profit Recovery/Collection**: The ID provided to you by Transworld for Profit Recovery and/or Collection service.

6. **"Paid in Full" thank you letter**: Check this box to have TSI send a thank you letter to patients once the balance is paid.

7. **Exclude Positive Adj Type**: Select a positive Adjustment (203) type that will be excluded from updates to TSI.

8. **Exclude Negative Adj Type**: Select a negative adjustment type that will be excluded from updates to TSI.

9. To enter different credentials for another clinic, select the clinic, then repeat steps 4 - 7.

10. **OpenDentalService Send Time**: Select when data will be sent and sync with Transworld. We recommend setting at time after business hours.

11. **Repeat Every**: Select how often the OpenDentalService will send and sync accounts. The recommended setting is one time per day.
   - Click the up/down arrows to increase/decrease the value.
   - Click the down arrow to select Days, Hours, or Minutes.

12. **Paid in Full Billing Type**: Select a non-collection (C) billing type to auto-assign to accounts once the balance has been paid in full.

13. Click **OK** to save all settings.

**Note**: The OpenDentalService Send Time and 'Repeat Every' settings are not clinic specific. They affect every clinic.

---

**Step 3: Create a TSI Collections Billing Type**

Open Dental will automatically assign this billing type to all accounts that are sent to TSI.

1. In the Main Menu, click Setup, Definitions.
2. Select Billing Types.
3. Click Add.
4. Enter a name to use for the billing type that will be auto-assigned to guarantors that have been sent to TSI (e.g. Transworld).

5. In the second box, enter C to mark this billing type as the **collections** billing type.
   - **Note**: There should only be one C billing type. If there are multiple, TSI will always assign the C billing type listed first.
   - Once a patient is sent to TSI, TSI will be responsible for billing the patient, so it is good practice to remove that billing type from the **Billing List** (504) so they are not billed by the office as well.

**Warnings**:
- Do not manually assign the TSI C billing type to any patient. Manual assignment will not initiate TSI account management. Thus the account could fall through the cracks.
- Do not manually change a patient's billing type from the TSI C billing type to another. Manual changes will not stop TSI account management, though will stop account syncing that could result in double, yet different statements.

---

**Disable the TSI Service in Open Dental / Hide the TSI button**

1. In the Main Menu, click Setup, Program Links. Double click on Transworld.
2. Uncheck the **Enabled** box.
3. Check the **Hide Unused Button** box to hide the button in the Manage Module.
4. Click OK to save.

**UAppoint Bridge**
In the **Main Menu**(592), click Setup, **Program Links**(934). Double-click on UAppoint.

UAppoint was a Program Link that allowed patients to search online for available appointment slots. UAppoint is no longer offered and the feature is obsolete in Open Dental.

**Vipersoft Bridge**
In the **Main Menu**(592) click Setup, **Program Links**(934). Double-click on Vipersoft aka Clarity.
Vipersoft is no longer sold. It was renamed as Dentrix Clarity.

To enable the bridge:
1. Check the Enabled box.
2. Verify the Path of file to open.
3. Double click on Additional Properties to change settings. You can use the PatNum (enter 0) or ChartNum (enter 1) as the patient ID.
4. Set up a clickable bridge button.
   1. Under Add a button to these toolbars, highlight where to display the button.
   2. Enter the Text on button.
   3. (Optional) Import an image to show on the button (22 x 22 pixels).
4. If using clinics, click Hide Button for Clinics. Select which clinics the button should display on.
5. Click OK.

**Technical Data**
The bridge sends the patient last name, first name, middle name, provider first and last name, and SSN.

**visOra Bridge**
In the Main Menu(592), click Setup, Program Links(934). Double-click on visOra from www.visoraimaging.com.
visOra is a digital imaging software. Website: www.visoraimaging.com.

To enable the bridge:
1. Check the Enabled box.
2. Verify the Path of file to open.
3. Double click on Additional Properties to change settings. You can use the PatNum (enter 0) or ChartNum (enter 1) as the patient ID.
4. Set up a clickable bridge button.
   1. Under Add a button to these toolbars, highlight where to display the button.
   2. Enter the Text on button.
   3. (Optional) Import an image to show on the button (22 x 22 pixels).
4. If using clinics, click Hide Button for Clinics. Select which clinics the button should display on.
5. Click OK.

Technical Details
Uses command line arguments for Pat ID, LName, FName, DOB, SSN, and Gender.

VistaDent Bridge
To enable the bridge:
1. Check the Enabled box.
2. Verify the Path of file to open.
3. Double click on Additional Properties to change settings. You can use the PatNum (enter 0) or ChartNum (enter 1) as the patient ID.
4. Set up a clickable bridge button.
   1. Under Add a button to these toolbars, highlight where to display the button.
   2. Enter the Text on button.
   3. (Optional) Import an image to show on the button (22 x 22 pixels).
4. If using clinics, click Hide Button for Clinics. Select which clinics the button should display on.
5. Click OK.

Technical Details
Open Dental launches VistaDent.exe with command line parameters.

Example:
VistaDent.exe -first="John" -last="Doe" -id="1589" -DOB="1980-12-15" -sex="m"

Remote desktop enhancement for enterprise users: In version 16.2.38 and 16.3, the VistaDent bridge can be used with the RemoteExecuter.exe for remote sessions.
The Path of file to open should contain the path to RemoteExecuter. The website for downloading the software is www.mqtechnologies.com.

Enter the path of the program to launch, like VistaDent.exe, in the Optional command line arguments field.

The optional command line arguments are then passed to the remotely connected computer and the VistaDent.exe path is found on the local computer instead of the remote computer.

VixWin (Numbered) Bridge

In the **Main Menu**(592), click Setup, **Program Links**(934). Double-click on a **VixWin (numbered)**.

Contact Open Dental support prior to troubleshooting any VixWin related issues.

![Program Link](image)

Gendex VixWin is imaging software. Website: www.gendexxray.com.

The recommended bridge is VixWin (numbered). When using this bridge, images will be stored in subdirectories based on Open Dental patient number, thus eliminating all performance issues linked to other VixWin versions. The last two numbers in the PatNum identify the first directory level. The second directory level is named the full PatNum. If you currently use a different VixWin bridge, see Other VixWin Bridges below.
To enable the bridge:
1. Check the **Enabled** box.
2. Verify the **Path of file to open**.
3. Double-click on a row in **Additional Properties** to change settings.
   1. You can pass across the PatNum (enter 0) or ChartNum (enter 1) as the patient ID.
   2. The Image Path is required and you must use a mapped drive letter. The same drive letter and path must exist on all workstations that use VixWin. In addition, each workstation's VixWin settings (Options, Preferences) must be set to Bridge mode using the same mapped drive letter.
3. Set up a clickable bridge button.
   1. Under **Add a button to these toolbars**, highlight where to display the button.
   2. Enter the **Text on button**.
   3. (Optional) Import an image to show on the button (22 x 22 pixels).
4. If using clinics, click **Hide Button for Clinics**. Select which clinics the button should display on.
5. Click OK.

**Note:** VixWin will not recognize UNC paths. You must use mapped drive letters.

**Troubleshooting**

**VixWin crashes when using Windows 10 and opening VixWin via Open Dental.**

Make sure the VixWin image drivers are updated to 3.6 or greater.

**Other VixWin Bridges**

If you currently use one of the VixWin bridges listed below, we recommend you contact us.

- VixWin (old)
- VixWin (new)
- VixWin base 36
- VixWin base 41

**XDR Bridge**

In the **Main Menu**(592), click Setup, **Program Links**(934). Double-click on XDR from **www.XDRradiology.com**.
To enable the bridge:
1. Check the Enabled box.
2. Verify the Path of file to open.
3. Enter a Local path override if needed.
4. Verify the InfoFile path.
5. Enter the Location ID as assigned by XDR.
6. If using clinics, select the Clinic from the dropdown.
7. Select how XDR will open using the XDR Patient ID.
   - PatientNum: Uses the automatically assigned patient number from Open Dental.
   - ChartNum: Uses the manually assigned chart number from Open Dental.
8. Enter the Text on button.
9. Under Add a button to these toolbars, highlight where to display the button.
10. (Optional) Import an image to show on the button (22 x 22 pixels).
11. Click OK when finished.

**Technical Data**

This bridge sends patient data to the specified InfoFile. It then launches XDR and passes the name of the InfoFile as a command line argument.

The Open Dental user that launched the bridge will transfer to XDR to ensure the correct database is selected.

XDR now has a standalone MySQL installer that creates a separate MySQL service named MyXDR which uses port 3310 (MySQL for OD uses port 3306). The typical XDR install location is `C:XDR\MyXDR`. The complete install, including the
bin and data directories are in that location. The drive will vary depending on customer needs and hardware setup. The MyXDR instance should not interfere with any current or future install of MySQL, so long as it does not use port 3310.

**Multiple Locations**

XDR can store images in 3 different ways:
1. Flat files and folders.
2. Hybrid, where metadata is in SQL database, but images are in files.
3. SQL database, with images stored directly in the database itself.

For multiple locations, the currently recommended solution is to use a single central SQL database to store images. All locations should be connected by a fast VPN, and then the images are all accessed from each location by connecting to the SQL database.

**Z-Image Bridge**

In the [Main Menu](592), click Setup, [Program Links](934). Double-click on Z-Image from [www.visoraimaging.com](http://www.visoraimaging.com). Z-Image is digital imaging software. Website: [www.cieos.com](http://www.cieos.com).
To enable the bridge:
1. Check the **Enabled** box.
2. Verify the **Path of file to open**.
3. Double-click on **Additional Properties** to change settings. You can use the PatNum (enter 0) or ChartNum (enter 1) as the patient ID.
4. Set up a clickable bridge button.
   1. Under **Add a button to these toolbars**, highlight where to display the button.
   2. Enter the **Text on button**.
   3. (Optional) Import an image to show on the button (22 x 22 pixels).
4. If using clinics, click **Hide Button for Clinics**. Select which clinics the button should display on.
5. Click OK.

**Technical Details**

Uses command line arguments for Pat ID, LName, FName, DOB, SSN, and Gender.

### Quick Paste Notes Setup

In the **MainMenu**(592), click Setup, Quick Paste Notes.

![Quick Paste Notes](image)

Alternatively, right-click in a **Right Click Text Box**(319) that supports quick notes and select **Insert Quick Note**.

**Using Notes**

Quick paste notes are templates for frequently used **Notes**(320). Assign shortcuts to templates to quickly insert notes in designated Right-Click Text Boxes throughout the program.

Some quick notes come default with the program. To use a quick note in a text box:
1. Enter ? followed by the note shortcut abbreviation (e.g. ?anx). The abbreviation is immediately replaced with the full note (Anxiety).
2. Or right-click and select **Insert Quick Note**. Select a category, then double-click an existing note.

**Categories**
Organize similar types of notes by category. Each category is assigned a default text box type that supports quick notes and only note shortcut abbreviations in this category will work in those text boxes.

**Description**: The name of the category.**

**Default for Types**: The text box type the category’s note shortcuts can be used with. Multiple types can be assigned to a single category. To assign more than one type, click the ctrl key while selecting a type. Types can be assigned to more than one category.

To delete a category and all the associated notes, select a category and click **Delete**. Use the **Up** and **Down** arrows to change the order the categories are listed. Changing the order of categories may affect a quick notes shortcut availability in a text box.

- **Note**: Quick paste notes used in tasks must have a type of **Task**. If another type is used, the ? shortcut will not work.
- **The types for JobManager and EmployeeStatus can be ignored as they are only used at Open Dental Headquarters.**

**Notes**

Select a category to view its quick paste notes on the right. Each line represents a note template.  
**Abbr**: The shortcut to insert the note in a text box.  
**Notes**: The note or preview of the template. Longer templates appear as one row in the preview but are inserted in text boxes as the user formatted.

To edit or delete a note or a note shortcut, select the note and click **Edit** (double-clicking inserts the note). To create a new note click **Add**. The **Edit Quick Paste Note** window will open.
**Abbreviation:** Enter the shortcut to use to insert the note in a text box (optional). Numbers, letters, and symbols or a combination of can be used. For the shortcut to work avoid using the same abbreviation as other notes or the same sequence of characters. For example, if di and dia are used as abbreviations, di will override dia. If no abbreviation is entered, no shortcut is assigned to the note. To insert notes without a shortcut, open the Quick Paste Notes list and double-click a note.

**Note:** Enter the full note text or a template. There is no limit to note size and it can span multiple lines.

Example: Abbreviation = di. When the shortcut ?di is entered in a text box, 'Diabetes' immediately replaces the abbreviation. The text box where the note is inserted also must have the note's category as its default. See Categories above.

To organize notes within a category, select the note and use the Up/Down arrows at the bottom of the Notes list. Or sort the notes alphabetically by abbreviation or the first character of each note. Check Abbreviation or Note and click Alphabetize.

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**Reports Setup**

To access report setup options, users must have the Setup permission.

In the MainMenu(592), click Setup, Reports.

Alternatively, from the Standard Reports(1278) window, click Setup in the upper left corner.

There are four setup areas. Click a tab to access the area:

- **Display Settings(1090):** Control the appearance of the Reports window, including which Standard Reports are listed, the sort order of reports, and report name.
- **Security Permissions(1092):** Control access to individual reports by user group.
- **Report Server(1094)**
- **Misc Settings(1096):** Set default report options.

---

**Report Setup: Display Settings**

In the MainMenu(592), click Setup, Reports.
Alternatively, from the Standard Reports(1278) window, click Setup(1090) in the upper left. Open the Display Settings tab.

Report display settings control the appearance of the Standard Reports window, including which reports are listed, the sort order of reports, and report name.

All available reports will list, grouped by category, and sorted in the order they will appear on the Reports window.

**Sub Menu:** Click in the Sub Menu column to show the report in the standard reports sub menu.
- Blank: Report will not show in the sub menu.
- X: Report will show in the sub menu.

**Hidden:** Click in the Hidden column to toggle between hiding/showing a report.
- Blank: Report will show in the Reports window.
- X: Report will not show in the Reports window.
Three reports are hidden by default: Provider Payroll Summary, Provider Payroll Detailed, and Net Production Detail Daily.

**Reorder:** To change the sort order of a report, highlight it, then click the up/down arrows. Reports can only be reordered within a category, not moved to a different category.

**Rename:** To change the report name that shows in the Report window, click in the DisplayName cell, then type the new name. The internal name of the report will always list in the lower right when a report is highlighted.

<table>
<thead>
<tr>
<th>Display Name</th>
<th>Hidden</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aging of A/R Renamed</td>
<td></td>
</tr>
</tbody>
</table>

Note: To remove the Business Analytics and Patient Review buttons from the Reports window, in the Main Menu, click Setup, Program Links(934), then disable the bridge and select *Hide unused button*.

**Report Setup: Security Permissions**

In the Main Menu(592), click Setup, Reports.
Alternatively, from the Standard Reports window, click Setup. Select the Security Permissions tab.

All available reports will list, grouped by category.

Report security permissions control access to individual standard reports, by user group.

User Group: Select the user group.

Allowed/Blocked: Click in the Allowed column to toggle between allowing or blocking report access. Or click Set All to quickly grant access to all reports.
- X: User group can access the report.
- Blank: User group cannot access the report.

When the user does not have access to a report [Locked] shows next to the report name when the user is logged on.
Click OK to save.

Note: There are two Security Permissions (Setup, Security) that control whether or not a user can access financial reports for other providers:

- **Production and Income, View All Providers**: User can access Production and Income reports for all providers. If a provider does not have this permission, they can still view their own reports, but only when they are logged on.

- **Daily - View All Providers**: User can access the Daily Payments, Daily Procedures, Daily Adjustments and Daily Write-offs reports for all providers. If a provider does not have this permission, they can still view their own reports, but only when they are logged on.

A provider without the above permissions can also view reports for a second provider that has the same first and last name (e.g. one provider in Open Dental represents patients with private insurance, and the second provider represents Medicare patients, but they are the same physical provider). This is a unique case.

**Report Setup: Report Server**

In the Main Menu (592), click Setup, Reports.
Alternatively, in the Standard Reports(1278) window, click Setup(1090). Select the Report Server tab.

A report server can be useful to large offices to prevent lockups and slowness in a live database. Currently the report server can run the following Reports(1276):

- Production and Income
- Daily Adjustments
- Birthdays
- Capitation Utilization
- Finance Charge
- Insurance Plans
- Prescriptions
- Receivables Breakdown
Setting up the Report Server

There are two connection options:

- Direct Connection
- Middle Tier

Note: Always keep the report server database up-to-date so reports are run on current data.

Check Use separate reporting server to enable the connection settings.

Enter the connection credentials for the desired connection method (see below).

Click OK to save.

To set up the report server:

Direct Connection

- **Server Name**: The name of the computer acting as the report server.
- **Database**: The database to connect to.
- **MySQL User**: Default user is root. See MySQL Security.
- **MySQL Password**: The user password (if you have set up MySQL users and password).

Middle Tier, URI: If you do not know your URI, see Middle Tier Troubleshooting for help.

Note: When connecting via Middle Tier, the credentials of the logged on user are used to access the database.

Report Setup: Misc Settings

In the Reports Setup window, click the Misc Settings tab.
Miscellaneous settings in Standard Reports controls default options for standard reports.

Check a box to select a setting; uncheck a box to deselect.

**Wrap columns when printing:** Set whether or not column text will wrap to the next line when printing complex reports and user queries.
- Checked: Column text will automatically wrap if needed.
- Unchecked: Text will not wrap.

**Show PatNum: Aging, OutstandingIns, ProcsNotBilled:** Set whether or not the patient number shows with patient name in the Aging of A/R, Outstanding Insurance Claims, and Procedures Not Billed to Insurance reports.
- Checked: Patient number will be included (e.g. 40-Dawn, Trisha).
- Unchecked: Patient number will not be included (e.g. Dawn, Trisha).
Monthly P&I scheduled production substracts PPO write-offs:
- Checked: Automatically subtract the write-off amount from anticipated production in Monthly Production and Income Reports (Scheduled column). This only applies to future dates where the work has not been completed and only affects insurance plans with a PPO Percentage plan type.
- Unchecked: Do not automatically subtract the write-off amount from anticipated production in Monthly Production and Income reports.

Default to showing clinic info on Daily P&I report: Set the default setting for Show Clinic Info on Daily Production and Income report.
- Checked: By default, the report will print in landscape, show a clinic column, and can optionally be grouped by clinic (Show Clinic Info checked).
- Unchecked: By default, the report will print in portrait mode and clinic information won't show (Show Clinic Info unchecked).

Default to showing clinic breakdown on P&I reports: Set the default setting for Show Clinic Breakdown in Production and Income reports.
- Checked: By default the report will group by clinic (Show Clinic Breakdown checked).
- Unchecked: By default, the report will group by date and intermingle clinics (Show Clinic Breakdown unchecked).

Show a verbose history when previewing reports: Set the default setting for verbose history when running reports via the Complex Report System.
- Checked: By default, a report query will populate when a complex report is run. The query shows the elapsed time of each generated item in the report. This is useful for large offices whose reports take a long time to generate. Click Copy to Clipboard to save the history and paste into a document.
- Unchecked: A report query will not populate when a complex report is run.

Allow using today's date in Provider Payroll report: Determines whether or not the Provider Payroll Production and Income Report (detailed) allows including today's date.
- Checked: Allow the date range to include today's date.
- Unchecked: Block the date range from including today or future dates. For example, if you capture Claim Snapshots at the end of the day via Service, you may want to block today's date.

Calculate write-offs by claim snapshot for today's date in Net Production Detail report: Determines which amount to use as the write-off in the Net Production Detail Report.
- Checked: Use the write-off amount in the Claim Snapshot for today's date.
- Unchecked: Use the write-off amount for the current Claim Procedures (claimprocs) (221).

Incomplete Procedure Note Report defaults: These settings determine the default state for corresponding checkboxes in the Incomplete Procedure Notes Report.
- Include procedures without a note in the Incomplete Procedures Report: Set the default state for the Include procedures for patients with no notes on any procedure for the same day checkbox.
  - Checked: Box will be checked.
  - Unchecked: Box will be unchecked.
- Include procedures with a note that is unsigned in the Incomplete Procedures Report: Set the default state for the Include procedures with a note that is unsigned checkbox.
  - Checked: Box will be checked.
  - Unchecked: Box will be unchecked.

Assume all procedures are in the General benefit category by default in the Treatment Finder report:
- Checked: Procedures for a patient apply towards annual max by assuming the procedures are in the general category.
- Unchecked: Does not apply all procedures to the general category.

Default to 'Date Range' tab in Outstanding Insurance Report: See Outstanding Insurance Claims Report (1315).
• Checked: Report defaults to *Date Range* tab view.
• Unchecked: Report defaults to *Days Old* tab view.

**Default selected date for PPO write-offs:** Set the default setting for *Show insurance write-offs* in Production and Income, PPO Write-off, Daily Write-off, Monthly Production Goals, Custom Aging and Receivables Breakdown reports. See [Show Insurance Writeoffs](1290) for more details.

- **Insurance Pay Date:** Default to use the date of insurance payment.
- **Procedure Date:** Default to use the date the procedure was completed.
- **Initial Claim Date/Ins Pay Date:** Default to using a combination of initial claim date for write-off estimates, and then insurance pay date for write-off adjustments.

### Schedule Setup

Schedule setup lets you view and enter all provider and employee schedules.

To view the schedule, in the [Main Menu](592), click Setup, Schedules.

Alternatively, in the [Manage Module](487), select a specific employee(s). Click **View Schedule**.

You can define any kind of rotating or alternating schedule you want. Enter individual work hours, holidays, lunch hours, and staff meetings.
Note: To edit schedules, the Schedules - Practice and Provider security permission is required.

Once schedules are entered, open/closed hours will be indicated in the Appointment module with the background colors set in Definitions: Appointment Colors (843).

- **Schedule Edit** (1101): Add employees or provider time to the schedule, or change the schedule for one day.
- **Schedule Graph** (1104): A visual display of a day's schedule.
- **Schedule View Employee** (590)

Note: The schedule may be blank until a provider or employee is selected and refresh is clicked.

Each day is represented by one cell. Today's date and schedule shows in red text. The filter options on the left control what shows in each cell.

- **From/To Dates**: The date range currently displayed on the window. Click Refresh to update the schedule.
- **Show Practice Holidays and Notes**: Show practice notes and holidays entered via the Edit Day window.
- **Show Clinic Holidays and Notes**: Only an option when clinics is turned on. Show the selected clinic's holidays and notes entered via the Edit Day window.

**Clinic**: Only an option when clinics is turned on. Select a clinic and only its scheduled providers will show. The default clinic is the one selected in the Main Menu (592). You must have access to a clinic to view its schedule. Initially the schedule will only show dates, notes, or holidays. Select providers and employees to populate the schedule with provider and employee names and hours.

**Limit to Ops in Clinic**: Only an option when clinics is turned on. Check the box to filter to operatories with the selected clinic and view the scheduled time blocks. While in this view, all buttons in the lower left are disabled and schedules can't be edited.

**Providers() / Employees()**: The providers and employees selected determines which schedules show. Whether providers/employees are selected by default is determined by the Manage Module Preferences (744), Select all provider/employees when loading schedules.

- Providers: Only lists providers who have access to the selected clinic.
- Employees: Only lists employees who have access to the selected clinic.

Select providers/employees then click Refresh to show their scheduled hours. To select multiple providers/employees, click and drag, or press Ctrl or Shift while clicking. The number currently selected appears in parentheses.

- **Show Weekends**: Show Sunday and Saturday schedules. To apply changes to weekends, weekends must be shown.
- **Clear Week**: Clear all schedule entries for the selected providers and employees, for the selected week.

Clear multiple weeks, you can also go to a blank week, copy it, then repeat it. Make sure the Replace Existing box is checked (for example repeat it for 20 weeks to clear 20 weeks.)

- **Copy**: Copy a day or week's schedule to the clipboard. This is a useful tool (with Paste/Repeat below) to quickly fill the schedule.
  - Copy Day: Copy the selected day only.
  - Copy Week: Copy the entire week based on the selected day.

**Paste**: Paste the copied day or week's schedule to a new day or week. Or repeatedly copy it for a specific number of days or weeks into the future.

- Warn on Provider Overlap: Receive a warning when provider schedules overlap in assigned operatories when you click Paste or Repeat. Checked by default.
- **Replace Existing**: Check this box to overwrite any existing schedules when you click Paste or Repeat.
Repeat: Paste the copied day or week repeatedly for a specific number of days or weeks. Enter the number of days or weeks next to #.

Note: When pasting over an existing schedule, a warning will popup indicating the number of providers whose schedule will be replaced.

Days marked as a holiday will not be replaced when pasting a schedule.

Print: Print the schedule for the selected date range.

Schedule Edit
In the Main Menu(592), click Setup, Schedules(1099). Double-click a day to edit.

Alternatively, in the Appointments Module(1), Employee or Provider tab, double-click anywhere.

The Edit Day window in Schedule Setup(1099) lists all provider and employee time blocks scheduled for one day. From here you can add, edit, and delete time blocks, as well as add holidays, staff vacations, and days the office is closed.

Date: The upper left corner shows the selected day. Click the arrows to move forward or back one day.

List tab: Show all provider and employee time blocks as rows (start/stop time, operatory and any notes) and any practice notes. The list is sorted first by practice notes, then by provider, then by employee. Double-click a row to edit.

Graph: View a graph representation of provider and employee time blocks. See Schedule Graph(1104).

Use the panel on the right to add time blocks, notes, and holidays, and select a default provider for operators.

Search: Search the days schedule by employee or provider name.

Clinic: When adding a time block, holiday, or clinic note, first select the clinic the time block applies to.

Providers: Lists providers who have access to the clinic. When adding a time block, first highlight the providers it will apply to. To select multiple providers, click and drag, or press Ctrl or Shift while clicking. The number of providers currently selected appears in parentheses.
**Employees**: Lists employees who have access to the selected clinic. When adding a time block, first highlight the employees it will apply to. To select multiple employees, click and drag, or press Ctrl or Shift while clicking. The number of employees currently selected appears in parentheses.

**Default Prov for Unassigned**: Select a default provider schedule to use for operators that have no provider assigned. If no operators have an assigned provider, this provider's schedule is used to indicate the office's open hours on the appointment schedule. The assigned provider cannot have any operators associated with their schedule.

**Add**: Add time blocks for the selected providers and employees. See detailed instructions below.

**Note**: Add a specific note for the selected providers and employees. This text box supports right click options. These notes will appear next to the employee/provider's scheduled hours in the Appointments module under the Employee tab (Notes column).

**Delete**: Remove a time block. The design of this feature is intentional so users can quickly schedule without multiple confirmations.
- If you have no time blocks selected and click Delete, all time blocks will highlight and you will be asked to confirm the deletion of all entries.
- If you select a time block, then click Delete, the selected time block will be deleted without asking for confirmation. If you delete a time block by mistake, click Cancel and the deletion will not be saved.
- If you delete via the Graph tab, the entire day's schedule will be deleted.

**Clinic/Practice**: Holidays and notes show as their own row under Edit Day and will only show on the schedule window if Show Practice Holidays and Notes or Show Clinic Holidays and Notes is also selected. Practice = Headquarters. See detailed instructions below.
- Note: Add a general note, e.g. about staff vacations or days the office is closed.
- Holiday: Add a holiday to the schedule.

**OK + Goto Schedules**: Only visible when opened via the Employee or Provider tab in the Appointments module. Saves changes and opens the main schedule window.

**Add to Schedule**
To fill the schedule, begin by entering provider and employee time blocks for one day. Once one day is set up as you like, you can quickly fill the schedule using copy/paste/repeat.

The date shows in the upper left. Click the left or right arrow to move back or forward one day. Currently scheduled providers and employees for the day show under the List tab, Edit Day. Double-click a row to edit a schedule. Usually time blocks are added/edited using the List tab. To add via the Graph tab, see Schedule Graph.

1. Select the clinic in the upper right corner.
2. Highlight the providers and/or employees the new time block will apply to. In each tab, only providers/employees that have access to the selected clinic will list. To select multiple names, click and drag, or press Ctrl or Shift while clicking. The number of selected providers/employees shows in parentheses.
3. Click Add.
**Note**: If both providers and employees are selected, a confirmation message will display first.
4. Use the dropdowns to select the Start and Stop time or enter a time using the same format (00:00 AM).

5. (optional) Usually providers are assigned to operatories. When an operatory is assigned to a time block it will override the operatory provider. This is useful when providers share operatories.
   - If an operatory is assigned to a time block, a colored vertical Time Bar (7) will show in the Appointments schedule to the left of the time block (operatory time bar). Only one dentist timebar and one hygienist timebar can show simultaneously.
   - If using clinics, an operatory must be selected and only operatories assigned to the selected clinic are options.

6. Enter any notes specific to this time block. This text box supports right click options (Right Click Text Box (319)). These notes will appear next to the employee/provider's scheduled hours and under the Appointments module, Employee tab (Notes column).

7. Click OK. If an operatory conflict or overlap is detected, a confirmation message will show. Click Yes to proceed or No to repeat step 7. For each time block created, a row will list under Edit Day.

8. Click OK on the Edit Day window to save and close.

**Delete Time Block**
Deletting a time block: If you have no time blocks selected and click Delete, all time blocks will highlight and you will be asked to confirm the deletion of all entries. If you select a time block, then click Delete, the selected time block will be deleted without asking for confirmation. If you delete a time block by mistake, click Cancel and the deletion will not be saved. The design of this feature is intentional so users can quickly schedule without multiple confirmations.

**Examples**
Schedules that Alternate Weekly:
1. Set up one week the way you like it.
2. Copy that week and paste it using Repeat 16 to fill approximately 4 months.
3. Alter one of the weeks to represent the alternate schedule. Copy that week, then paste one week at a time to each of the 8 alternating weeks.

Taking every third Friday off:
1. Set up the standard schedule for a few months.
2. Double-click on one Friday, highlight all time blocks, and click the Delete button.
3. Copy the day, then paste one day at a time to the Fridays you take off.

**Enter Holidays**
A holiday is an officially recognized holiday like Christmas, not a day that the office is simply closed or the dentist is on vacation. The holiday text will show in the day's cell on the schedule grid and in Graph View. In the Appointment schedule,
the day's background will be the color set in Definitions: Appointment Colors(843), Holiday. To notate the holiday on the appointment schedule, add Blockouts(10). Holidays are considered when calculating lab case due dates.

1. Double-click on the day to open the Schedule Edit(1101) window.
2. If needed, remove all time blocks for the day. To delete multiple time blocks at once, press Ctrl+click to highlight, then click Delete.
3. In the Practice or Clinic area, click Holiday.
4. Enter the Holiday text in the Note box, then click OK.

**Enter Vacations/Office Closed**

To enter information about an employee or provider’s vacation or days the office is closed, enter a note. The note text will show in the day's cell on the schedule grid and in Graph View. It will not show in the Appointment module.

1. Double-click on the day to open the Edit Day Window.
2. If needed, remove all time blocks for the day. To delete multiple time blocks at once, press Ctrl+click to highlight, then click Delete.
3. In the Practice or Clinic area, click Note.
4. Enter a description (e.g Dr. Smith Vacation, Office Closed), then click OK.

To add holiday or vacation hours to an employee's time card, see Manage Time Cards(583).

**Schedule Graph**

A graph of the Schedule is available to give you a visual representation of each provider and employee's work schedule for a single day.

In Schedule Setup(1099), double-click a day. Click the Graph tab.
Alternatively, in **Schedule Edit** (1101), click the Graph tab.

The graph is divided into 15 minute time segments. A vertical bar indicates the current time. Click the arrows in the upper left to move forward or back one day.

**Clinic**: Select the clinic’s schedule to view.

**Sort**: Sort the chart by start time, stop time, or employee/provider name.

**Filter**: Select what should appear in the chart.
- **Notes**: Display any practice or clinic notes. These will appear first.
- **Providers**: Display all scheduled providers. These will appear second in the list, as a group.
- **Employees**: Display all scheduled employees. Employees are identified by name, and any notes entered in their time block show.

**Scale**: Select the start and end hour to display.
- $0 = 12:00$ AM
- $24 = 12:00$ PM

To add or enter time block, holiday, or notes, use the panel on the right. See **Schedule Edit** (1101).

If you Delete from the Graph tab, the entire day’s schedule will be deleted.
Security

In the MainMenu, click Setup, Security, Security Settings.

Setting up security for the Open Dental program will help protect patient data and track user access. This is an important component of a security plan as well as a requirement for HIPAA compliance.

- Only users with the Security Admin security permission can access the Security area.
- Every person who uses Open Dental should have a unique username and password for logging on.
- Other options, such as automatic log-off and lock dates, can also be set.

Webinar: Security and User Permissions

Also see: Permissions

Tracking authorized use of Open Dental: Every time a user logs in, logs off or closes Open Dental, an entry is created in the Audit Trail. Another option is to use the Windows audit feature. Set up Windows so that each user is required to log in separately, then use the Security Log to view valid and invalid log attempts. To view the Windows audit log go to My Computer, right-click and choose Manage, expand Event Viewer, expand Windows Logs, left-click on the Security log.
**Settings**: Access [Global Security Settings](1107).

**Users**: A list of all users that meet the User Filter criteria. Double click to [Edit User](1109). To add a new user, click **Add User** at the top right of the grid.

**User Groups for**: The highlighted groups are the user groups the selected user is associated with. Users can be associated with multiple groups. Clicking on a user group will change the user group assigned to the user that is highlighted.

**Effective permissions for user**: A read-only list of the user group’s assigned permissions (Checked = allowed, Unchecked = not allowed). To change a user group’s assigned permissions, click the **User Groups** tab.

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**Global Security Settings**

In the [Security](1106) window, at the upper left, click **Global Security Settings**.

![Global Security Settings](image)

Settings affect all users.

**Time Card Security Enabled**:
- **Checked**: Enables the *Users cannot edit their own time card* box (see below). Limits users without the *Edit All Time Cards* permission from viewing other employee timecards.
- **Unchecked**: Disables the *Users cannot edit their own time card* box.
**Users cannot edit their own Time Card:** This option can only be changed if the Time Card Security Enabled box is also checked. The setting of this box will override the *Edit All Time Cards* security permission.
- **Checked:** Individual users cannot make changes to their time card.
- **Unchecked:** Individual users can make changes to their time card. Since error fixing is tracked well in time cards, most offices keep this box unchecked because it is useful when employees can make notes and fix errors.

**Disable Monthly Backup Reminder:**
- **Checked:** The monthly [Backup Reminder](542) will no longer show. Do not disable unless you have an established backup and recovery process (for HIPAA compliance). A password is required to change this option. It is abracadabra.
- **Unchecked:** The next backup reminder will show one month after the date it is deselected.

**Log off when Windows logs off:**
- **Checked:** Automatically logs the current user out of Open Dental whenever they log out of Windows.

**Passwords must be strong:**
- **Checked:** All passwords must be at least 8 characters and contain at least one number, one uppercase letter, and one lowercase letter.
  - **Note:** If using Mobile Web and passwords are changed to must be strong, users who do not have a strong password must change passwords to meet the criteria before they can access the Mobile Web. Users who already have a strong password do not need to go through this process.
  - **When passwords must be strong, a password is required when adding a new user.**
- **Unchecked:** Strong passwords are not required.

**Strong passwords require special character:**
- **Checked:** When passwords must be strong, the password must also contain at least one special character (e.g. #, $, !).
- **Unchecked:** A special character is not required.

**Force password change if not strong:**
- **Checked:** When passwords must be strong, users who do not have a strong password will be required to change their password the next time they log on so it meets criteria.
- **Unchecked:** Users will not be required or prompted to change to a strong password.

**Manually enter logon credentials:**
- **Checked:** Requires users to manually type their user name when logging in.
- **Unchecked:** Users will select their user name from a list.

**Default User Group:** Select the default user group to apply to new users added via the main menu, Setup, Security, Add User. Groups that have the **Security Admin** permission enabled cannot be used as a Default User Group. See [User Edit](1109).

**Automatic logoff time in minutes (0 to disable):** Set a time when, after a period of inactivity, Open Dental will automatically log off the current user. Enter 0 if you do not want an automatic log off time. If automatic log off is turned on, and you manually click Log Off, any unsaved changes will be lost, and no warning message will show.

**Domain Login:** See [Single Sign-On / Domain Login](1108).

**Global Lock:** See [Security Lock Dates](1122).
Domain Login is more commonly referred to as single sign-on. Setting up single sign-on will allow users to automatically log into Open Dental using their associated Windows domain user. Each time the user is logged on automatically, there will be an entry in the audit trail. This feature is useful for large enterprise offices.

- Note: Your network must be on an Active Directory domain controller.
- Each workstation must be connected to the same network as the domain controller.
- A direct connection is required. To use single sign-on with Middle Tier, see Middle Tier.
- If the Admin user has a blank password in Open Dental, the associated domain user login will be ignored and the Admin will be logged in.

Enable Domain Login
Check Domain Login Enabled.

Enter the LDAP URI as the Domain Path (e.g. LDAP://DC=[DomainName],DC=[TopLevelDomain] or LDAP://[DomainName]).

Click OK to close the Global Security Settings window.

Add Domain User to Open Dental User
On the Security(1106), Users tab, double click on a user.

On the User Edit Window(1109), click [...] next to Domain User and select the domain user.

Click OK to save.

Technical Details
Logging on remotely (e.g. from a laptop): When a user is logging on remotely, they will need to set up a VPN connection to the same network as the domain controller.

Single sign on works in a Terminal Server environment.
1. Remote App: Single sign on will login as normal. The user logged into the workstation will be used to log on for single sign on.

User Edit
In the Security(1106) window, click Add User in the Users grid, or double-click to edit an existing User.
Alternatively, in the MainMenu(592), click Setup, Security, Add User.

Note: To add a User, the User must have the "Security Admin" Permission(1119) or Add User Permission(1118). Also, a default user group must be set in Global Security Settings(1107).

**UserID**: This is an internal unique identifier that is useful for third party reporting.

**Domain User**: Only visible if Domain Login (Single Sign on) is turned on. Click [...] and select the domain user.

**Name**: Enter the employee's user name for logging on to Open Dental.

**DoseSpot UserID**: If this is a provider using DoseSpot eRx, enter the userID assigned by DoseSpot. For providers with multiple DoseSpot UserID numbers, click [...] to add the corresponding DoseSpot UserID for each clinic. See DoseSpot Setup(343).

**User Group**: Highlight the User Groups the user will be assigned to. Users can be assigned to more than one group. User groups control which permissions a user has.

**Employee (for timecards)**: Highlight the employee associated with the user. Required for offices using Time Clock(582).

**Provider**: Highlight the Provider(1252) associated with the user.

**Create Password**: Click to create the password the user will use to log on to Open Dental. If a password exists, the label will be Change Password(598).
Enter the password, then click OK. By default the password shows as asterisks. To instead show the character in readable text, click Show. Each user can later change their password.

Note: For HIPAA compliance, each user should have a unique, protected password that only they know. This is especially important for providers because some actions performed when the provider is logged-on are equivalent to signatures, such as writing procedure notes or electronic prescriptions.

Require Password Reset: (optional) Check this box to prompt the user to reset their password upon first log in.

Is Hidden: Hide this user from the Log On window. Useful when an employee leaves the office. Users cannot be deleted.

Unlock Account: See Unlock Account (1114). Accounts are temporarily locked for five minutes after more than five consecutive failed attempts to log on to Open Dental or the Mobile Web. This button only shows when editing a user.

Clinics Tab
Only visible if using Clinics (1505).
**User Default Clinic**: Highlight the user's default clinic. Only one option can be selected. If All is selected, Headquarters will be the default. Usually this clinic will be selected automatically when the user logs on.

**User Restricted Clinics**: Associate a user to one or more clinics (optional). See below for a list of items that are affected by clinic restrictions.
1. Highlight the clinics the user should have access to. To select multiple clinics, click and drag, or press Ctrl while clicking.
2. Check **Restrict user to only see these clinics**.

Note: If you do not want to restrict your providers and prefer that they have access to all clinics, but you do want to filter the provider lists by clinic so users are presented a smaller list based on which clinic they treat patients at, you can do this from **Provider Setup** (1255), Clinics Tab.

When a user is restricted to specific clinics, they will face limitations in the following areas:
- Only clinics the user has access to will list in the Main Menu, Clinics.
- Only patients in clinics the user has access to will show when selecting patients.

Users can be granted the **Unrestricted Search** permission to access all clinics when selecting patients.
- User can only see alerts for clinics they have access to (when the clinic is selected in the main menu).
- Billing
- Recurring Charges
- Charges
- Reports
- Viewing and Sending Claims
- Time Card Management (if also have the time card manage permission).
- Time Clock (only show employees for their allowed clinic).
- Scheduling
- Fee Schedules
When providers are restricted to clinics, it may affect the available provider options in some areas (e.g. the only providers showing in lists will be those who have access to a clinic). These areas include:

- Operatory Setup
- Edit Appointment window
- Edit Patient Information
- Adjustments
- Edit Claim Window
- Payment Plan
- Pay Splits
- Broken Appointment Procedure window
- Edit Procedure window
- Schedule Setup

Example: If Provider A is restricted to Clinic A, Provider A will not be an option for primary or secondary provider when editing patient information for a patient assigned to clinic B.

**Alert Subs Tab**
Subscribe the user to specific alerts. See Alert Subscription(1113). Alerts show in the main menu to notify the user about important information.

**Technical Details**
As of 18.3, password hashing has been updated from the MD5 encryption standard to SHA3-512.

**Alert Subscription**
In the User Edit(1109) window, click the Alert Subs tab.
See Alerts (1635).

**User Alert Subscriptions**: Highlight the alert categories to subscribe the user to. Click and drag, or press Ctrl while clicking to select multiple categories.

**Clinics Subscribed**: If using Clinics (1505), highlight the clinics the user will see alerts for. Take into consideration any clinic restrictions (set in the Clinics tab). Users can only see clinic alerts when they have access to the clinic.

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**Unlock Account**

In the User Edit Window (1109), click Unlock Account.

Users can become locked when invalid credentials have been entered several times in a row. Unlock this user so that more log in attempts can be made?

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After more than five consecutive failed attempts to Log On (1121) to Open Dental or the Mobile Web Feature, a user will be temporarily locked out for five minutes or until the account is manually unlocked.
Click OK. A confirmation will show.

Click OK. The user can attempt to log on again.

**User Group**

In the *Security*(1106) window, click the User Groups tab.
Every **User** is part of at least one user group. The user groups created here are available to assign to Users.

**Users currently associated**: At the right is a list of all users currently assigned to the selected user group. Users can be assigned to multiple user groups.

To add a group, click **Add Group**. To rename a group, double click the group name, or select it and click **Edit Group**. Before a user group can be deleted, all users must be moved to another user group.
Note: To create a special set of permissions for a single user, create a user group just for that individual.

Set Permission
Each Permission controls a user's access to, or use of, an Open Dental feature or log a user's actions in the Audit Trail (1424). Permissions are assigned by user group. See Permissions (1118) for a list of all permissions and their behavior. If you are unsure of what permissions to assign to each user group, it is simplest to start with all permissions on a temporary basis, and then gradually add restrictions, as needed.

Set All: Quickly assign all permissions, except the "Security Admin" Permission (1119), to the selected user group.

Individual boxes may also be checked or unchecked. If you check a box for a permission with a User Group Lock Date (1122), then this window will come up.

This will let you prevent alteration of historical data. To set a date limitation, enter a value in the Date or Days field, then click OK to save. If left blank, there will be no lock date.

Date: Changes will only be allowed if they are newer than the date entered. A typical date might look like 3/31/2019, which would close out the month of March.

Days: Changes will only be allowed if they are newer than the days listed. 1 will give permission for today. 2 will give permission for today and yesterday. The maximum number of days allowed is 3,000.

Note: See Global Lock Date (1122) to prevent backdating of new items, or to lock for multiple permissions and groups at one time.
Permissions
In User Group(1115), there is a list of Permissions for each User Group.

Refer to the table below for details about each permission and its behavior.

- **Permission**: The name of the permission as it appears in the Security window.
- **Internal Name**: The name of the permission as defined in Open Dental code. This information is useful for programmers and when reading the audit trail.
- **Behavior**: What the permission allows a user to do in Open Dental. Buttons a user doesn't have permission to use are frequently hidden or grayed out. There are different kinds of behavior.
  - Allow or block access to an area.
  - Edit individual items. This almost always includes delete permission as well. Users without the permission can still see the item.
  - Create new items.
- **Lock Dates**: User Group Lock Dates and Global Lock Dates work independently of each other. See Lock Dates(1122).
  - User Group Lock Date: Permissions that can have day or day limits set by user group. For example, only allows users in a user group to change insurance payments if they occur within a set amount of days or before a specific date.
  - Global Lock Date: Permissions affected when a Global Lock Date is set at the bottom of the Security window. The Global Lock Date prevents editing of old items or entry of new backdated items.
- **Audit Trail**: Indicates if the permission is tracked in the Audit Trail.

This table has been ommitted.

"Setup" Permission
The Setup Permission(1118) covers a wide variety of setup functions. Below is a list of what it allows/blocks.

- Printer Setup
- Appointment Module Preferences
- Custom Appointment Fields
- Appointment Rules
- Appointment Types
- Appointment Views
- Operatories
- Recall
- Recall Types
- Family Module Preferences
- Claim Forms
- Clearinghouses
- Insurance Categories
- Insurance Filing Codes
- Patient FieldDefs
- Payer IDs
- Account Module Preferences
- Treatment Plan Module Preferences
- Chart Module Preferences
- Some options on EHR setup window (Allergies, Vaccine Def, Drug Manufacturer, Drug Unit, Reminder Rules, Inbound Email, Educational Resources, EHR Triggers, Time Synchronization)
- Procedure Button Setup
- Image Preferences
- Imaging Quality
- Manage Module Preferences
- Email
- Messaging
- Messaging Buttons
- Time Cards
- Advanced Setup: Computers, HL7, Replication, Show Features
- Auto Codes
- Automation
- Auto Notes
- Data Paths
- Definition Setup
- Dental Schools
- Display Fields
- Fee Schedules
- Setting up Dental Laboratories
- Miscellaneous Setup
- Module Preferences
- Practice,
- Program Links
- Requirements Needed
- Schedules
- Security
- Sheets
- Spell Check
- Tools: Aging, Clear Duplicate Blockouts, Create A to Z Folder, Merge Patients, Shutdown Workstations, Telephone Numbers, Test Latency, Aging, Audit Trail, Billing/Finance Charges, CC Recurring Charges, Database Maintenance, Mobile Synch
- Lists: Procedure Code List (changing procedure information), Counties, Dental School Classes, Dental School Courses, Employee List, Problem List, Prescriptions, Sites.
- Add and delete Email Templates, Supply Inventory Categories, Standard Report Setup.
- Access Setup window in Update (1639).

Setup log entries are also added to the audit trail in the following situations:
- A user clicks eConfirm Activate/Deactivate or eReminder Activate/Deactivate (eConfirmation and eReminder Setup).
- Web Sched automation is turned on or batch size changes.
- The Setup window is accessed in Update.

"Security Admin" Permission

The Security Admin Permission (1118) allows access to administrator functions. At least one user must have this permission. It allows/blocks a user from the following:

- Locking Accounting (546) entries.
- Clean Up Allowed tool. Fee Schedules (914)
- Access to eCW Program Link (986).
- Access to create users and move patients in the Providers (1252).
- Use Undo in the Recall List (27).
- Delete Recall Types (635).
- Access to the Audit Trail (1424).
- Access to Dental School Setup (896) (Dental Schools).
- Access to the Etrans tool in Database Maintenance (1434).
• Make changes to Setup in Update (1639).

A Security Admin log entry is also added to the Audit Trail when:
• A user clicks Stop Monitoring on the eServices Setup, eConnector (1520) Service window.
• A user edits permissions for a user group.
• The user group is changed for a user.
• The Registration Key is changed.

Dental School Security

Dental Schools (808) security include assigning User Group (1115) and permissions, setting default user groups for students and instructors, and setting up usernames and passwords for logging on to Open Dental.

User Groups and Security Permissions

All users should be assigned to a user group which determines the user’s Security (1106) permissions. You will need at least three types of user groups. Carefully consider which permissions each user group should have.

• Admin users: Usually have access to most if not all permissions, including:
  o Security Admin: Define users, user groups, security permissions.
  o Setup: Access to setup functions, including dental courses and classes.
  o Instructor Edit: Create and edit providers that are instructors.
  o Student Edit: Create and edit providers that are students.
  o Admin Evaluation Edit: View and edit student evaluations; cannot create.

Note: The admin user (with the Admin Evaluation Edit security permission) cannot create student evaluations because they are usually not instructors. Only instructors can create evaluations.

• Instructors: All instructors have the ability to create student evaluations; this is not related to a security permission. However, to set up evaluations, the instructor user group should have the Setup security permission. Instructors should
not have the *Admin Evaluation Edit* security permission as this will block them from creating student evaluations. [Dental School Evaluation Setup](#)(897)

- Students: Students should not have access to permissions that involve system setup or security.

To create a user group and assign security permissions, see [User Group](#)(1115).

**Assign Students and Instructors a User Group**
See [Dental School Setup](#)(896).

**User names and passwords**
Each student and instructor will need a unique username and password to log on to Open Dental. These can be defined when setting up the [Dental School Instructors](#)(1261) or [Dental School Students](#)(1263).

**Log On**
When Open Dental starts, if the user [Security](#)(1106) is properly setup, the Log On window should open.

To protect data and prevent misuse, every user should be required to log on with a unique user name and password, then log off when they leave the workstation. See [Security](#)(1106) to set up user profiles and assign permissions.

- **Note:** If you are not prompted to log on when you start the program, an Admin user does not have a password setup, thus all users are logging in automatically as the Admin.
- If a user's current password does not meet password criteria, they may be required to create a new password that does.
- To force a user to change their password the first time they use it to login, check Require Password Reset when setting up the [User Edit](#)(1109).
- After five consecutive failed attempts to log on, a user will temporarily be locked out of the account for five minutes or until a user with Security Admin privileges manually unlocks the account. See [Unlock Account](#)(1114).
- The screen differs based on whether the setting for *Manually enter logon credentials* is on or off. If on, the user will need to manually type their username and password.
Note: To set up single sign on (LDAP), see Single Sign-On / Domain Login(1108).

Logging Off
To log off manually, in the main menu, click Log Off. A message will appear, warning that you are about to be logged off of Open Dental.

To disable the Log Off message, check the box for Do not show me this message again. This setting is independent for each user.

To reinstate the Log Off message for a user, see User Settings(601).

- Note: Set automatic log off options in Global Security Settings(1107).
- If you log off and there are unsaved changes, a warning message will show. If automatic log off is turned on, and you manually click Log Off, any unsaved changes will be lost, and no warning message will show.

Security Lock Dates
In the Global Security Settings(1107) window, near the bottom, is the Global Lock Date section.

Click Change.
Global lock dates prevent editing of old items, and are additionally the only way to prevent backdating of new items. See the full list of Permissions to identify which permissions are affected by global lock dates.

**Date**: Locks the date entered, as well as prior dates. A typical date might look like 12/31/2018. This is frequently used to close out each year.

**Days**: Changes will only be allowed within a set amount of days from the original entry date.

**Lock includes administrators**: Apply the limitation to users in the Admin user group.

Note: If setting global lock dates, we recommend showing write-offs in reports using insurance payment date. See Show Insurance Writeoffs.

**User Group Lock Dates**
There are also date and day limitations for individual User Groups. These limitations show in the main Security window, at the right as (if date/days newer than...).

The limitations for User Groups are based on the date the item was entered, not necessarily the date that shows in the patient account. This means that backdating is allowed because the entry date is tracked. Use global locks above to prevent backdating of new items.

- **Note**: If both user group and global lock dates are set, the more restrictive lock date will apply.
- **Existing Other (EO) and Existing Current (EC) procedures are not considered in lock dates.**

**Sheets**
Sheets are templates that can be customized, then used to gather and send information electronically.

In the Main Menu, click Setup, Sheets.
Sheets can include text, images, information from the database, input fields, checkboxes and radio buttons, signature boxes, and freehand drawing. Open Dental has several internal sheets that can be used for patients, or copied and edited as needed.

Webinars: Sheets I, II, III, Kiosk

Internal: The original sheet templates that come with Open Dental. Cannot be edited, but can be copied.

Custom: Sheet templates that have been customized or created by your office.

Label assigned to patient button: Select a custom label to print when clicking the Label button in the Main Toolbar (1649).

Sheet Type Filter: Select to filter the sheets list by type.

Copy: Select an internal sheet from the list on the left and click copy to create a custom version to edit.

Defaults: Click to open Sheet Def Defaults (1151) window.

Tools: Click to open Sheet Tools Import / Export (1155) window.

New: Create a new blank custom sheet.

Duplicate: Highlight a Custom sheet in the list and click Duplicate to create a new copy. For example: duplicate a custom letter sheet to create a second version that can be customized with a different body of content.

- Edit Sheet Def (1125)
  - Sheet Def Properties (1129)
- **Sheet Field Types** (fields, images, checkboxes/radio buttons, signature boxes, grids, formatting, etc.)
- **Web Forms Feature**
- **Kiosk Manager** (1444)
- **Fill Sheet** (1152)
- **Import Patient Forms and Medical Histories** (1692)
- **Sheet Troubleshooting** (1190)

Sheet Types:
- **Consent Form Layout** (1156)
- **Deposit Slip Layout** (1158)
- **ERA Layout** (1159)
- **ERA Grid Header Layout** (1160)
- **Exam Sheet Layout** (1161)
- **Lab Slip Layout** (1162)
- **Label Layout** (1163)
- **Medical History Layout** (1165)
- **Patient Form Layout** (1171) (e.g. reg. form, HIPAA, financial agreements)
- **Patient Letter Layout** (1172)
- **Payment Plan Layout** (1174)
- **Screening Layout** (1176)
- **Referral Letter Layout** (1178)
- **Referral Slip Layout** (1180)
- **Routing Slip Layout** (1181)
- **Rx Instructions Layout** (1183)
- **Rx Layout** (1181)
- **Rx Multiple Layout** (1184)
- **Statement Layout** (1186)
- **Treatment Plan Layout** (1188)
- **Chart Layout** (460)

**Form Design Services**

If you have existing forms you would like to convert to sheets, but don't have the time or expertise to set them up, we can help. At this time, we do not have a library of forms to pick from, so you will need to supply the wording. Usually the entire original paper form is enough. The process may involve converting backgrounds to an image. If you can supply a native program file (e.g. a Word document or PDF, not a scanned image), the setup cost may be reduced.

Please contact Open Dental support to get started. For fees, see **Fees for Support and Services**.

**Edit Sheet Def**

Open Dental has several internal sheets that can be copied and customized for your practice.

In **Sheets** (1123), click **New**, or double-click an existing sheet to Edit.
On the left is a preview of the fields and elements currently on the sheet and their location on the page. Sheet layout displayed onscreen will match what is printed. If the sheet is multiple pages, a darker dotted line represents the page break. In the example above:

- A background image is used for the static text (black).
- Input fields and checkboxes (blue) have been superimposed on the image to indicate data entry areas.
- The input fields correspond to fields in the database. If completed electronically, the entered data can be imported into the database.

See our video on Mobile Web Forms: Web Forms Tutorial.

**Mobile**: Click to open Edit Mobile Sheet Def(1127) window.

**Edit Properties**: Click to make changes to Sheet Def Properties(1129) (e.g. name, default fonts, page orientation, page size).

Add or edit Sheet Field Types(1130).

To edit a field or element, double-click on it in the preview, or double-click on it in the Fields list.

To edit an image or line, double-click on the item in the Fields list.

To set up fields that can be imported into the database, see Medical History Layout(1165) or Patient Form Layout(1171).

To select multiple fields, press Ctrl while clicking.

To move fields, drag them with the mouse, or use the arrows on the keyboard.
To move the fields in large increments, press Shift while pressing the arrows.

**Setup Auto Snap:** Click to enable grid. Auto Snap makes it easier to move fields and ensure they are aligned.

Enter a value between 10 and 100 (pixels) to enable. Based on the value entered, a grid will appear in the background of the Edit Sheet Def window to assist in aligning elements.

**Hints**

If using a sheet for **Web Forms Feature**, the view of the sheet is dependent on the browser the web form is viewed in. If a browser doesn't support a font, a different font will be substituted. This can affect layout of the sheet. We recommend using common fonts (e.g. Times New Roman, Arial, Courier) and testing sheets on a device and browser you plan to support. If fonts are substituted, Static Text Fields may need to be larger to fit all text.

**Single Page Sheets:** If a single page sheet, make sure all fields and elements are located within the page.

**Adding Initial Boxes:** To add initial boxes so a patient can distinctly acknowledge sections of a form, you have two options:

1. Create a pseudo margin so you have room on the right or left side of the form. Add checkboxes as the initial boxes and a signature box at the bottom. Patients can check the boxes, then sign at the bottom to establish identity and acknowledgment.
2. If using touch screens, use Rectangles larger than checkboxes, labeled 'initials'. Customer can then use a finger or stylus to initial.

Checkboxes are usually sufficient for an electronic form because electronic signatures will be invalidated if the state of a checkbox changes (e.g. from unchecked to checked).

**Edit Mobile Sheet Def**

In [Edit Sheet Def](#), at the upper right, click **Mobile**.
Registration Form

This will toggle a pane on the left that shows a view that is optimized for mobile. Mobile layout is available for patient forms, consent forms, and medical histories.

See our video on Mobile Web Forms: Web Forms Tutorial.

Sheets enabled with mobile layout can be used in eClipboard.

Double-click a Sheet Input Field (1135) to edit. Drag and Drop to change the order of the fields.

Note: Mobile sheets do not support images. If you are using a scanned image as a background in the desktop version of your sheet, it will not show for mobile layout users.

**Use Mobile Layout:** Check to enable mobile version of sheet for use with Web Forms.

**Add Header:** Click to add a header to the mobile layout of the sheet.
Sheet Def Properties

In Sheets, double-click a Sheet Definition. Click Edit Properties.

Sheets general properties include a name, font defaults, width/height, and page orientation.

- **Description**: Name of the sheet.
- **Sheet Type**: Determines where the sheet will be available. Once a type is assigned it cannot be changed. (e.g. sheets with a PatientForm and MedicalHistory type are available when you click Forms.)
- **Bypass Global Lock**: Typically only checked for Exam Sheets. When checked this sheet will not be affected by the Global Lock Date (1122) (if turned on). Exam sheets that existed in a patient's chart prior to version 17.2 are not affected by this setting.
- **Default Font name and size**: The default font properties used when you create fields. Font support is dependent on the browser used to view the web form. We recommend using common fonts (e.g. Times New Roman, Arial, Courier) and testing sheets on a browser and device you plan to support. If a browser doesn't support a font, a different font will be substituted. This can affect layout of the sheet. Static text fields in particular may need to be larger to fit text.
- **Width/Height**: The width and height of each page of the sheet. These values should not be larger than the size of the paper that the sheet will be printed on. A standard letter sized sheet is 850w x 1100h.
- **Landscape**: When checked, sets the page orientation to landscape. When unchecked, sets the orientation to Portrait.
Sheet Field Types

In a custom Sheet(1123), various Sheet Fields can be edited, added, or formatted.

The fields available show in the panel on the right of the Edit Sheet Def(1125) window. Availability of fields varies by sheet type.

Field Types

Click a button on the right side of the screen to insert a sheet field.

- **Output Text**(1131): Output data fields that will be pulled from the database so information doesn't need to be entered manually. Output fields vary based on sheet type. For example, the output fields available for DepositSlip sheets differ from output fields available for ReferralLetter sheets.
- **Static Text**(1133): Text information such as labels and large paragraphs. Over 100 output text fields can be inserted as static text so that resulting text is specific to the patient (e.g. patient address, gender, insurance carrier 0 to 30 day balance, insurance remaining and recall interval).
- **Input Field**(1135): Fields that expect the user to input data. Data can be imported into the database.
- **Line**(1137): Fixed lines for the background.
- **Checkbox**(1138): A defined area where the user can click to toggle an X on and off. Can allow multiple choices or be set as radio buttons that require users to select one option out of many.
- **Rectangle**(1137): Fixed rectangles for the background. Used to create the actual box for a checkbox/radiobutton.
- **Static Image**(1141): Import large or small graphic images (jpg, gif, png, tif, bmp).
- **Signature**(1143): Insert a box for an electronic signature. Electronic signatures are tied to other sheet data (except images) and will be cleared if information changes.
- **SigPractice**: As above, but limited to Treatment Plan(1188) sheets. Useful for recording the presenter's signature in addition to the patient's.
- **ComboBox**(1144): Add pick lists that allow users to make a single selection from a list of options.
- **Pat Image**(1145): Add patient images stored in the Images module (bmp, gif, exif, jpg, png, and tiff). This can be useful to show pre and post treatment images. If you plan to include multiple images in a sheet, store each image in a separate folder.
- **ScreenChart**(1146): Add up to two tooth charts to a custom public health screening form. There are two charts: one for treatment planned procedures and one for completed procedures. When sealant procedures are marked, the procedure is automatically added to the patient's chart.
- **Grid**(1147): Insert a fixed group of items arranged in columns and rows.
- **Special**(1149): Add the tooth chart and tooth chart legend.

As you add fields, the items will show in the Fields list. Double-click a field to edit or delete.

Do not overlap fields. Overlapping fields will cause annoyances. There is no way to set which fields draw first, so if you try to put a checkbox on top of a paragraph of text, for example, then the checkbox could easily be hidden under the white background of the text box.

Some exceptions:
- Any field may be placed on top of a background image
- A checkbox can be placed on top of a rectangle
- If you need images to overlap (e.g. to create a page header) use a third party software to do so, then save as a single image.

The fields available for a sheet depend on the sheet type: This table has been ommitted.

Adding or Removing Pages

A sheet can be up to 10 pages long.

**Add**: Append one page worth of editable space to the end of the sheet. Top and bottom margins will be applied. Page break is indicated by a darker dotted line.
**Remove**: Remove one page of editable space from the end of the sheet. You cannot remove space that contains fields.

- **Note**: Items should not be placed on a page break line. Any fields on a page break line will be divided in two when printing.
- Blank pages at the end of the sheet will be removed when Filling Out the Sheet.
- If using Web Forms, each sheet must contain input fields for first name (FName), last name (LName), and Birthdate.

**Vertical and Horizontal Alignment**
The alignment options are useful for aligning columns or rows of checkboxes or text fields. First select multiple elements, then click an alignment button to perform an action.

**Top**: Align all selected elements with the top-most selected element.

**Left**: Align all selected elements with the left edge of the left-most element.

**Center**: Align all selected elements in the center.

**Right**: Align all selected elements with the right edge of the right-most element.

**Copy/Paste**
**Copy**: Copy the selected element to the clipboard.

**Paste**: Paste a copied element to the sheet. Pasted elements appear in the upper left corner of the preview panel.

**Tab Order**
Define the order followed when users fill out the form and press Tab. Tab orders can be used on Input Fields and Checkboxes.
1. Click Tab Order to switch the window will switch to tab order mode.
2. Click on each field to assign its tab order. The corresponding order number will appear on the field and in the Fields list.
   - To remove a tab order, click on the field again (it will change to zero).
3. To exit tab order mode, click Tab Order again.

**Tips**
Hotkeys are supported when editing sheets. Click the tips link in the lower right corner to see the supported hotkeys:

**Ctrl+C**: Copy

**Ctrl+V**: Paste

**Alt+Click**: 'Rubber Stamp' paste to the cursor position.

**Click + Drag**: Click on a blank space then drag to group select.

**Ctrl + Click + Drag**: Select multiple fields, then move as a group.

**Delete or Backspace**: Delete current selection.

**Sheet Output Text Field**
In **Edit Sheet Def**(1125), click OutputText.
Output Text fields are Sheet Field Types(1130) that pull information from the database when filling out the form.

For example, a time/date output field will auto-populate with the current date or a PracticeTitle field will populate with the practice name. If the sheet type is previewed prior to printing, you can edit output text on the generated form.

**Field Name**: A list of available output fields for the sheet type.

For a list of all output text fields and their definitions, see Output Text Field Names(1133).

**Font**: These properties affect the appearance of the text.
- **Name**: We recommend using common fonts (e.g. Times New Roman, Arial, Courier) and testing sheets on a browser and device you plan to support. Font support is dependent on the browser used to view the web form. If a browser doesn't support a font, a different font will be substituted and this can affect layout of the sheet.
- **Size**: Font point size.
- **Bold** (checked) or not bold (unchecked).
- **Color**: Single click the color block to Select Text Color.
- **Align**: The position of text within the field (right, left, center).

**Growth Behavior**: This attribute can be set when it is not known ahead of time how large the output text will be. Setting the growth behavior causes a field to grow bigger; it will never cause a field to shrink. Click the dropdown to select an option:
- **None**: No growth behavior.
- **Down Local**: Typically used for the address because it is not known ahead of time if it will span one or two lines. If the field grows to two lines, the fields immediately below are bumped down (like CityStateZip).
- **Down Global**: Useful for table style data and letter bodies. Bumps down all fields on the entire sheet that are below the field that's growing.

**X/Y Pos**: Determines the placement of the upper left corner of the output field in relation to the x and y axis. X = horizontal, Y = vertical.

**Width**: The width of the output field. If the text output exceeds the width, information will span multiple lines.
**Height:** The height of the output field. If font size is large, the height may need adjusted so all text is visible.

**Lock Text Editing:** When checked, the output text fields cannot be edited when the form is open (e.g. by a patient).

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**Output Text Field Names**

See [Sheet Output Text Field](#).

Output Text fields are [Sheet Field Types](#) that pull information from the database when filling out forms. This list is in progress and not all fields have a description yet. The available output text fields vary by sheet type. This table has been ommitted.

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**Sheet Static Text Field**

In [Edit Sheet Def](#), click *Static Text*.

![Static Text Field](image)

Static text fields are [Sheet Field Types](#) used for fixed text. You can optionally include output text fields within the fixed text. Static text fields are useful for field or checkbox labels or for larger paragraphs. If the sheet type can be previewed, static text is editable when filling out the form.

**TextBox:** Enter the static text in the large box. Text between brackets (e.g. [salutation]) are [Output Text Fields](#) that can be inserted to include patient-specific information such as address, gender, carrier, etc. The available output text fields are listed under *Click to insert Field*. Position the cursor at the insertion point, then single click the output text field to insert it. For patient letters, fields from custom exam sheets can be inserted. See Exam Sheet Field below.
For a list of static text fields and their definitions, see Static Text Field Names (1135). If there are other static text fields you would like added, please submit a feature request.

**Font**: These properties affect the appearance of the text.
- **Name**: We recommend using common fonts (e.g. Times New Roman, Arial, Courier) and testing sheets on a browser and device you plan to support. Font support is dependent on the browser used to view the web form. If a browser does not support a font, a different font will be substituted and this can affect layout of the sheet.
  - **Size**: Font point size.
  - **Bold** (checked) or not bold (unchecked).
  - **Color**: Single click the color block to Select Text Color.
  - **Align**: The position of text within the field (right, left, center).

**Growth Behavior**: This attribute can be set when it is not known ahead of time how large the text input will be. Setting the growth behavior causes a field to grow bigger; it will never cause a field to shrink. Click the dropdown to select an option:
- **None**: No growth behavior.
- **Down Local**: Typically used for the address because it is not known ahead of time if it will span one or two lines. If the field grows to two lines, the fields immediately below are bumped down (like CityStateZip).
- **Down Global**: Useful for table style data and letter bodies. Bumps down all fields on the entire sheet that are below the field that's growing.

**X/Y Pos**: Determines the placement of the upper left corner of the field in relation to the x and y axis. X = horizontal. Y = vertical.

**Width**: The width of the field. The width of the current static text is indicated to the right as a guide. If a field input exceeds the width, information will span multiple lines.

**Height**: The height of the field. If you increase font size, you may need to increase field height so that all text is visible.

**Is Payment Option**: This option only shows for Statement Sheets (1186). It designates the field as information that shows when payment information is included on a statement.

**Lock Text Editing**: When checked, the static text fields cannot be edited when the form is open (e.g. by a patient).

**Exam Sheet Field**: This option only shows for Patient Letter Sheets (1172). Insert a field from a custom exam sheet within the static text. Position the cursor at the insertion point, click Exam Sheet Field, then select the exam sheet and field. Four types of elements can be pulled:
- radio button groups with reportable names
- misc checkboxes with reportable names
- misc input fields with reportable names
- output text fields
Static Text Field Names

See Sheet Static Text Field(1133).

Static text fields are a type of Sheet Field(1130) used for fixed text. This list is in progress. Each field may not have a description. This table has been ommitted.

Sheet Input Field

In Edit Sheet Def(1125), click InputField.
Input fields are Sheet Field Types (1130) used to indicate areas where a user will enter data. They are commonly used in patient forms and medical histories where entered data can be imported directly to the database. (Import Patient Forms and Medical Histories (1692)).

Note: Medication, allergy, and problem input fields for medical histories require special setup.

Field Name: The available input fields for the selected sheet type.
- Database fields can be imported.
- misc can be used to collect information that doesn't correspond to a database field. The entered data cannot be imported, but can be reported in a custom query. Entered data is stored in the sheetfield.fieldvalue column in the sheetfield table. Make sure to enter a corresponding Reportable Name. An example of a custom query is at the bottom of this page.

Reportable Name: Only shows when misc is the field name. Enter an identifying name for the misc field.

Mobile Caption: Caption to identify field in mobile sheet.

Font: These properties affect the appearance of the text.
- Name: We recommend using common fonts (e.g. Times New Roman, Arial, Courier) and testing sheets on a browser and device you plan to support. Font support is dependent on the browser used to view the web form. If a browser doesn't support a font, a different font will be substituted and this can affect layout of the sheet.
- Size: Font point size.
- Bold (checked) or not bold (unchecked).

Growth Behavior: This attribute can be set when it is not known ahead of time how large the text input will be. Setting the growth behavior causes a field to grow bigger; it will never cause a field to shrink. Click the dropdown to select an option:
- None: No growth behavior.
• Down Local: Typically used for the address because it is not known ahead of time if it will span one or two lines. If the field grows to two lines, the fields immediately below are bumped down (like CityStateZip).
• Down Global: Useful for table style data and letter bodies. Bumps down all fields on the entire sheet that are below the field that's growing.

X/Y Pos: Determines the placement of the upper left corner of the field in relation to the x and y axis. X = horizontal. Y = vertical.

Width: The width of the input field.

Height: The height of the input field. If you increase font size, you may need to increase field height so that all text is visible.

Required: If checked, the user will be required to input data in the field before saving the form.

Tab Order: The order of the field when users press Tab on the generated form. (Hint: Click Tab Order in the right panel to view and edit the tab order of all elements on a sheet.

Query Example for a Misc Field
Each time data is input into a reportable name input field, the value is stored in the sheetfield.fieldvalue column in the sheetfield table. Below is an example query used to report on a 'misc' field for 'Hormone Sat Lev' for a specific date range:

/*Misc sheet field report for sheets created in date range*/
SET @SheetName='Hormone Survey'; /*Enter description of sheet here (sheet name)*/
SET @ReportableName='Hormone Sat Lev'; /*Enter the reportable name of the misc field here (from sheet field)*/
SET @FromDate='2015-01-01', @ToDate='2015-12-31'; /*Set sheet date range here*/
SELECT p.PatNum AS 'Pat#', CONCAT(p.LName,', ',p.FName) AS 'Patient Name',
sheet.DateTimeSheet, sheet.Description AS 'SheetName',sheetfield.ReportableName AS 'FieldReportableName', sheetfield.FieldValue AS 'FieldReportableValue'
FROM sheet
INNER JOIN patient p ON p.PatNum=sheet.PatNum
INNER JOIN sheetfield ON sheetfield.SheetNum=sheet.SheetNum
WHERE sheet.Description LIKE @SheetName
AND sheetfield.ReportableName LIKE @ReportableName
AND DATE(sheet.DateTimeSheet) BETWEEN @FromDate AND @ToDate;

Sheet Line and Rectangle
In Edit Sheet Def, click Line or Rectangle.

Fixed lines and rectangles are Sheet Field Types(1130) that can be added to a sheet background.

Lines: Enter X/Y position, width/height, and color. Negative width and height values are allowed.
Rectangles: Enter X/Y position and width/height.

X and Y Pos: Where the line starts in relation to the x and y axis. X = horizontal. Y = vertical.

Width: How far the line extends from the X/Y position (line length).

Height: How far up or down the line extends from the X/Y position. Entering a value here will make a diagonal line.

Color (Line only): Single click on the colored block to Select a Color.

Sheet Checkbox and Radio Button

In Edit Sheet Def(1125), click CheckBox.
Checkboxes and radio buttons are Sheet Field Types (1130) used to indicate a selection by toggling an X on or off.

Checkboxes allow one or many selections. Radio buttons allow only one selection out of a group of options. Both can correspond to a specific field in the database or be a misc field that does not.

Gender: [ ] M [X] F

The checkbox or radio button is the actual X, not a box surrounding the X. This makes it useful for scanned backgrounds. If you need to add a box, you can add a rectangle behind the checkbox or radio button as a visual indicator.

- Note: Suggested size for the checkbox is 11x11 and for a surrounding rectangle 12x12.
- Checkboxes and radio buttons for medical histories require additional setup. See Medical History Layout (1165).

Field Name: The available field options the checkbox can correspond to. The field you select may change other options on the screen.
- Database fields can be imported.
- Misc can be used to collect data that does not correspond to a database field. The entered data cannot be imported, but can be reported in a custom Query. Entered data is stored in the sheetfield.fieldvalue column in the sheetfield table. When misc is selected, the Reportable Name field shows. Enter an identifying name for this misc checkbox/radio button.
For a sample misc query, see Input Fields.

**Add Procedure:** Only available when editing a screening sheet. Allows a user to assign a procedure code to a checkbox. When checked, the procedure code will automatically chart.

**X/Y Pos:** Determines the position of the upper left corner of the checkbox in relation to the x and y axis. X = horizontal. Y = vertical.

**Width/Height:** The size of the checkbox/radio button. Suggested size is 11x11.

**Radio Button Group Name:** Only visible when *misc* is the field name. Used to create custom checkboxes or radio buttons not tied to a database field.

For radio buttons (single selection), enter a common name used for all radio buttons in the group. For checkboxes (one or many selections), enter a unique group name for the checkbox.

When using Yes/No checkboxes, you can choose to omit the No boxes. The Yes boxes will act as Yes when checked, and No when unchecked.

**Required:** If checked, the user will be required to select an option in the generated form before saving it. If adding radio buttons, all radio buttons in a group should be marked the same: all required or all not required.

**Radio Button Value:** Only visible when a database field is the selected field name. The values listed are based on database options. Create one radio button for each value.

**Tab Order:** The order of an element when users press Tab on the generated form. (Hint: Click Tab Order in the right panel to view and edit the tab order of all elements on a sheet.

### Creating Radio Buttons for Database Fields

These steps will create a group of radio buttons that correspond to database fields and whose values can be imported. You must create a radio button for each possible value in a radio button group for it to work correctly. If a user clicks one radio button in a group, the other buttons in the group automatically uncheck.

1. On the Edit Checkbox window, select the Field Name.
2. Select the first radio button value.
3. Click OK.
4. Move the radio button to the correct location (e.g. click and drag).
5. Click Checkbox again.
6. Select the same Field Name.
7. Select the next radio button value.
8. Click OK.
9. Move the radio button to the correct location (e.g. click and drag).
10. Repeat step 4 - 9 until all radio button values have an associated radio button.

**Creating Misc Radio Buttons**
These steps will create a group of radio buttons whose values cannot be imported, but can be reported in Custom Queries.
1. On the Edit Checkbox window, select `misc` as the Field Name.
2. For Group Name, enter a common name that will be used for all radio buttons in this group (e.g. Family Heart History).
3. For Reportable Name, enter a unique name for this option (e.g. Paternal Only, Maternal Only, Both, None). This is the name that will be reportable when this radio button is selected.
4. Click OK.
5. Move the radio button to the correct location (e.g. click and drag).
6. Click Checkbox again.
7. Select `misc` again.
8. Enter the same Group Name.
9. Enter another unique Reportable Name.
10. Click OK.
11. Move the radio button to the correct location (e.g. click and drag).
12. Repeat step 6 - 11 for all radio buttons in the group.

**Create a Misc CheckBox**
These steps will create a checkbox that allow one or many selections. Repeat these steps for each checkbox.
1. On the Edit Checkbox window, select `misc` as the Field Name.
2. For Group Name, enter a unique group name for this button (e.g. Paternal, Maternal).
3. For Reportable Name, enter a unique identifying name for this option.
4. Click OK.
5. Move the checkbox to the correct location on the sheet (e.g. click and drag).

**Sheet Static Image**
In `Edit Sheet Def(1125)`, click `StaticImage`. 
Static images are large or small images (Sheet Field Types) that can be imported into sheets. Images can be used for an entire background based on a scanned form or as smaller graphics (e.g. logos).

- Note: Supported image types are jpg, gif, png, tif, bmp. Word and PDF files must be converted to a supported image type before they can be imported.
- To add images that are patient specific, see Sheet Patient Image.
- Small images may make lines and rectangles not show. To fix, add a larger background image as well.
- Images are not tied to signatures, thus changes to an image will not clear or invalidate a signature. Place information that should invalidate a signature in a text field instead.

Freehand Drawing: To enable freehand drawing on the sheet, it must have a large enough image covering the entire drawing area. If you do not insert any images, Open Dental automatically adds an invisible white dummy image for drawing. If you insert an image, it must be large enough to cover the entire background, or you must insert a second image that does. If you do not, you may inadvertently disable drawing on the rest of the sheet.

File Name: Click the dropdown arrow to select an image from the OpenDentImages/SheetImages folder. Or click Import to select another image file. A preview of the image will show in the middle of the window.

X/Y Pos: Determines the position of the upper left corner of the image on the sheet in relation to the x and y axis. X = horizontal. Y = vertical.

Width/Height: The size of the image in pixels. To quickly resize an image to the largest size that will fit in the window, click Shrink to Fit. The File Size indicates the image’s original size.
Maintain Ratio: Check this box to maintain the same height to width ratio when resizing an image.

Sheet Signature Box
In Edit Sheet Def(1125), click Signature.

Signature boxes are Sheet Field Types(1130) that can be added for Electronic Signatures.

The generated form can then be signed directly on screen or using an external signature pad.

Electronic Signatures(306) are electronically tied to data on the generated sheet (except images). Once a sheet is signed and saved, the date and time of the signature will show in the signature box.

If data is changed the signature is automatically invalidated or cleared and the date/time stamp is removed. Multiple signature boxes can go on a single sheet.

- Note: Date and time do not show on signed payment plan sheets.
- Signature boxes are only useful for sheet types that can be previewed before printing. Labels, prescriptions (Rx), and routing slips are not previewed on screen so cannot be tied to electronic signatures.
- To add space for a written signature, add a line instead.
- When a Web Form contains a signature box, patients can electronically sign using a mouse or stylus, or they can opt to type their name. See Web Forms: What Patient Sees(1503).

X/Y Pos: Determines the position of the upper left corner of the signature box in relation to the x and y axis. X = horizontal. Y = vertical.

Width/Height: The size of the signature box.

Required: If checked, the user will be required to sign the generated form before saving it.
Sheet ComboBox

In Edit Sheet Def(1125), click ComboBox or double-click an existing combo box to edit.

![ComboBox Edit Window]

Combo boxes are Sheet Field Types(1130) that allow users to select a single option from a pick list.

<table>
<thead>
<tr>
<th>Place of Service:</th>
<th>MobileUnit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgency:</td>
<td>NeedsCare</td>
</tr>
<tr>
<td>Race / Ethnicity:</td>
<td></td>
</tr>
<tr>
<td>Grade Level:</td>
<td></td>
</tr>
<tr>
<td>Preferred:</td>
<td></td>
</tr>
</tbody>
</table>

Users will click the combo box to view options, then click an option to select it.

The list on the right indicates the current options in the combo box.

**X/Y Pos:** Determines the position of the upper left corner of the combo box in relation to the x and y axis. X = horizontal. Y = vertical.

**Width/Height:** The size of the combo box

**Tab Order:** The order of the combo box when users press Tab on the generated form

**Reportable Name:** A unique name tied to the combo box. Used to report this data in custom queries.
Add a Combo Box

Below are basic steps for adding a combo box to a sheet.
1. Click ComboBox.
2. Add options. There are two ways:
   Type the option in the Option box, then click Add.

Select a combo box type in the lower left to fill the list with preset options.
   o Patient Race, Patient Grade, and Urgency will fill the list with preset options. These options can be reordered, removed, or added to.
   o General will clear the list.

3. Change the width and height of the combo box so that it fits all text.
4. Click OK.
5. Move the combo box to the correct location on the sheet.

To remove a single option, highlight it then click Remove.

To reorder an option, highlight it, then click the up/down arrows.

Sheet Patient Image

In Edit Sheet Def(1125), click PatImage.

Patient images are a Sheet Field Types(1130) that adds a patient-specific image.

The image inserted in the generated sheet will be the image last added to the Images module category selected for the element. If you plan to include multiple images, store each image in a separate category. Supported image types include bmp, gif, exif, jpg, png, and tiff.

Examples:

• To show a patient’s picture, store all patient pictures in the same image category, then select the image category for this element.
• To show pre and post treatment images, create two PatImage sheet elements. The pre-treatment images should be stored in one image category; the post-treatment images should stored in another.

Image Category: Select the Images Module(480) category where the images are stored. When the sheet is created, the first image listed in the category will always be used.

X and Y Pos: Set the location of the upper left corner of the image in relation to the x and y axis. X = horizontal. Y = vertical.

Width: The width of the image.
**Height:** The height of the image.

Note: If an image is cropped in the Images Module, it will still display the full image here. Cropped images only show cropped within Open Dental, where the sheet pulls the image from the OpenDentImages folder.

---

**Sheet Screen Chart**

In **Edit Sheet Def** (1125), click **ScreenChart** to immediately insert a tooth chart in a sheet.

![Edit Screen Chart](Image)

Double-click on a chart to set teeth as primary or permanent. Click a radio button, then OK to save.

ScreenCharts are **Sheet Field Types** (1130) that can be added when **Screening Layout** (1176). There are two tooth charts available. Each chart shows posterior teeth and can be set to show permanent or primary teeth.

- If no screen charts are currently on the sheet, **ChartSealantComplete** will insert first.
  - **ChartSealantComplete:** To mark sealants that are complete.
- If **ChartSealantComplete** is already on the sheet, **ChartSealantTreatment** chart will insert, and vice versa.
  - **ChartSealantTreatment:** To mark current tooth status including treatment needed.
- Only two charts are allowed per sheet.

Note: Only sealants marked on permanent teeth will automatically add a matching procedure code to the patient's chart.

When using a custom screening form that has a tooth chart, users can click on a tooth or tooth surface to select a code that represents tooth status or needed treatment. There are six code options and they are described in the Code legend on the internal screening sheet:

- S = Seal
- PS = Previously Sealed/Intact
- C = Caries
- F = Filled
- NFE = Not Fully Erupted
- NN = Not Needed
- None = remove a previously marked code.

Teeth 2, 3, 14, 15, 31, 30, 19, and 18 allow a code per surface. You can mark a single surface or all.

When sealant procedures are marked on permanent teeth, a matching sealant procedure (D1351) is added to the patient's chart. Status of the procedure (treatment planned or complete) depends on which tooth chart the code is marked on. Surface information will be associated with the procedure, but not sent with claims.
Below is what the tooth charts look like on generated custom screening form. ‘S’ indicates teeth or tooth surfaces where a sealant code has been marked.

**Sheet Grid**

In Edit Sheet Def(1125), click Grid.

Grids are Sheet Field Types(1130) for use in certain sheets. They are a fixed group of information organized into columns and rows. They can be added to Statements(269), Treatment Plans(283), Referrals(76), and printed Payment Plan(239).

Select the grid type using the dropdown. The grid options vary depending on the sheet type.

(optional) Enter the X and Y position of the upper left corner of the grid in relation to the x and y axis. X = horizontal, Y = vertical.

Note: You can also click and drag the grid on the sheet itself to reposition it.

**Statement Grids**
There are five statement grid types.

**StatementAging**

<table>
<thead>
<tr>
<th>0-30</th>
<th>31-60</th>
<th>61-90</th>
<th>over 90</th>
</tr>
</thead>
</table>

**StatementEnclosed**

<table>
<thead>
<tr>
<th>Amount Due</th>
<th>Date Due</th>
<th>Amount Enclosed</th>
</tr>
</thead>
</table>

**StatementMain**: The columns can be modified in Display Fields, StatementMainGrid (column names, order, and size).

<table>
<thead>
<tr>
<th>Date</th>
<th>Patient</th>
<th>Code</th>
<th>Tooth</th>
<th>Description</th>
<th>Charges</th>
<th>Credits</th>
<th>Balance</th>
</tr>
</thead>
</table>

**StatementPayPlan**

**Payment Plans**

<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
<th>Charges</th>
<th>Credits</th>
<th>Balance</th>
</tr>
</thead>
</table>

**Payment Plan Amount Due: 0.00**

**StatementInvoicePayment**: The grid will populate with payments attached to procedures on the invoice as well as unattached payments that were made on the same day.

**Payments**

<table>
<thead>
<tr>
<th>Date</th>
<th>Prov</th>
<th>Patient</th>
<th>Type</th>
<th>Proc</th>
<th>Description</th>
<th>Amt</th>
</tr>
</thead>
</table>

**Total Payments: 0.00**

**Treatment Plan Grids**

There are three treatment plan grid types.

**TreatPlanMain**: At least one TreatPlanMain must exist in each treatment plan sheet. The columns can be modified in Display Fields, TreatPlanModule (column names, order, and width).

<table>
<thead>
<tr>
<th>Done</th>
<th>Priority</th>
<th>Tth</th>
<th>Surf</th>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
<th>Pri Ins</th>
<th>Sec Ins</th>
<th>Pat</th>
<th>Discount</th>
<th>Dx</th>
</tr>
</thead>
</table>

**TreatPlanBenefitsFamily**

**Family Insurance Benefits**

<table>
<thead>
<tr>
<th>Primary</th>
<th>Secondary</th>
</tr>
</thead>
</table>

**TreatPlanBenefitsIndividual**

**Individual Insurance Benefits**

<table>
<thead>
<tr>
<th>Primary</th>
<th>Secondary</th>
</tr>
</thead>
</table>

**Payment Plan Grid**

There is one payment plan grid.

**PayPlanGrid**

<table>
<thead>
<tr>
<th>Date</th>
<th>Provider</th>
<th>Description</th>
<th>Principal</th>
<th>Interest</th>
<th>Due</th>
<th>Payment</th>
<th>Balance</th>
</tr>
</thead>
</table>

**Referral Letter Grid**

There is one Referral Letter grid.

**ReferralLetterProceduresCompleted**
There is one grid for Patient Dashboards.

### ApptsGrid

<table>
<thead>
<tr>
<th>AppStat</th>
<th>Prov</th>
<th>Clinic</th>
<th>Date</th>
<th>Time</th>
<th>Min</th>
<th>Procedures</th>
<th>Notes</th>
</tr>
</thead>
</table>

There are two grids when using Chart Layouts.

### ProgressNotes

<table>
<thead>
<tr>
<th>Date</th>
<th>Th</th>
<th>Surf</th>
<th>Dx</th>
<th>Description</th>
<th>Stat</th>
<th>Prov</th>
<th>Amount</th>
<th>Proc Code</th>
<th>User</th>
<th>Signed</th>
</tr>
</thead>
</table>

### PatientInfo

<table>
<thead>
<tr>
<th>FieldName</th>
<th>FieldValue</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Sheet Special Field

In [Edit Sheet Def](1125), click **Special**.

Special fields are [Sheet Field Types](1130) used in [Treatment Plan Layout](1188), [Referral Letter Layout](1178), [Chart Layout](460), and [Patient Dashboard](1507).

**FieldName**: There multiple options depending on which sheet you are editing. See below for examples of each field.
**X and Y Pos:** Set the location of the upper left corner of the image in relation to the x and y axis.

- **X =** horizontal.
- **Y =** vertical.

Note: You can also click and drag an element on the sheet itself to reposition.

**Width / Height:** The width and height of the image. The tooth chart will always have a fixed width to height ratio.

**Tooth Chart**
The Tooth Chart fields can be added to the treatment plan sheet, referral letter sheet, chart layout, and patient dashboards.

- For treatment plan sheets, the tooth chart displays all procedures.
- For referral letters, the tooth chart only displays procedures completed the same day the letter is generated.

```
X and Y Pos: Set the location of the upper left corner of the image in relation to the x and y axis.
- X = horizontal.
- Y = vertical.

Note: You can also click and drag an element on the sheet itself to reposition.

Width / Height: The width and height of the image. The tooth chart will always have a fixed width to height ratio.

Tooth Chart
The Tooth Chart fields can be added to the treatment plan sheet, referral letter sheet, chart layout, and patient dashboards.
- For treatment plan sheets, the tooth chart displays all procedures.
- For referral letters, the tooth chart only displays procedures completed the same day the letter is generated.

toothChart

```

toothChartLegend (not available on Chart Layout)

<table>
<thead>
<tr>
<th>Existing</th>
<th>Complete</th>
<th>Referred Cut</th>
<th>Treatment Planned</th>
</tr>
</thead>
</table>

**Insurance**
Insurance fields can be added to patient dashboards.

```
Insurance
Insurance fields can be added to patient dashboards.

familyInsurance
dividualInsurance
```
Chart Module
The following fields can be added to chart layout sheets.

chartModuleTabs

Treatment Notes

TrackToothProcDates

Sheet Def Defaults
In Sheets(1123), click Defaults.
You can set a default Rx(1181) sheet to use when printing single prescriptions. If using Clinics, defaults can be set by clinic.

**Clinic:** If using Clinics, defaults can optionally be set for each clinic. Click the dropdown to select the clinic.

**Rx:** Click the Rx dropdown to select the sheet to use when printing single prescriptions.
- Sheets prefaced by 'Internal' refer to the internal version of the sheet.
- Default refers to the sheet selected for the Defaults clinic.

**Chart Layout:** Choose a Chart Layout(460) to be the default. This can be set per Clinic.

### Fill Sheet

In Sheets(1123), some are generated on-screen before printing, emailing, or saving.
These sheets can be filled in, edited, signed on the Fill Sheet window. Above is an example of a patient registration form.

- All text in input text fields, output text fields, and static text fields is editable.
- Input fields are indicated with a light yellow background.
- checkboxes and radio buttons can be selected/deselected (toggle an X on or off).
- Signature boxes accept electronic signatures. Once signed, the date and time of the signature will show. If a signature is invalidated or cleared the date/time stamp is removed.
- To enter information on a combo box, there are two options:
  - Click on the combo box and select from the dropdown list.
  - On your keyboard, tab to the combo box, use the space bar to open the dropdown list, use the arrow to select the item, then press Enter
- If a large enough drawing static image has been added, users can arbitrarily freehand draw anywhere on the form using a stylus or mouse.

**Date time:** Indicates the date and time the form is generated.
**Description**: Defaults to the sheet description set in Sheet Def Properties (1129).

**Internal Note**: Enter any notes.

**Show Order in Kiosk**: If adding this form to the Kiosk queue, enter the form's order in the queue. See Kiosk Manager (1444).

**Eraser Tool**: Check the box to turn the pointer into an eraser then click and drag, or use the stylus, to erase a drawing. A drawing is defined as a continuous curved line without lifting the pen, so a continuous line is considered a single object. Uncheck to turn the eraser off.

**Print/Email**: Print and/or email the form.

- **Paper copies**: Enter the number to print. The default value depends on the form or letter selected and the emails entered.
- **Email to Patient**: If an email is entered on the Edit Patient Information window it will show. Check the box to email the form or letter to the patient.
- **Email to Referral**: Only shows if creating a referral letter. If an email is entered for the referral on the Edit Referral window it will show. Check the box to email the letter to the referral.

If email is selected, the form or letter will be converted to a PDF and attached to the outgoing email.

Click OK. Paper copies are sent directly to the printer. Once printed or emailed, the form is archived in the database for later reference. Forms can be viewed at the bottom of the Account module or in the Chart module.

**Print**: Click Print to send the form directly to the printer. Prints one copy at a time.

**Email**: Click Email to open the Edit Email Message window with a PDF attached to the outgoing email. Finish sending the email from this window. See Email Message Edit (1656).

**Create PDF**: Generate a PDF version of the form.

**Change Patient**: Associate the sheet with a different patient. Select the patient then click OK to move the sheet. It will be viewable in the new patient's Progress Notes. Changing patients will not change or affect any information in the sheet (e.g. patient name).

**Delete**: Remove a sheet. The Sheet Delete security permission is required.
- Deleted sheets will no longer show in the Chart module or commlog but will still exist in the database.
- To view deleted sheets, open the Chart module in Audit mode (Show Chart Views (328), click Audit).

**Restore**: Deleted sheets have a Restore option. To restore a deleted sheet, double click it in Audit mode to open the Fill Sheet window, then click Restore.
Unlock: Applies to forms with an electronic signature box. Once a sheet is signed, it locks. Only users with the Sheet Edit security permission can unlock it.

Sheet Tools Import / Export

In Sheets(1123), click Tools.

Importing or exporting sheets will only benefit those who use Open Dental.

Sheets have a specific .xml file format requirement. You will never export a sheet .xml file for import into another program.

Import a Sheet

The format of the imported file must exactly match the sheet requirements (e.g. it has been exported from another Open Dental database).
1. In the Main Menu(592), click Setup, Sheets, then Tools.
2. Click Import.
3. Select the xml file to import, then click Open.
4. A message will indicate when the import is done. Click OK.

Export a Sheet

Only custom sheets can be exported.
1. In the Main Menu, click Setup, Sheets, then Tools.
2. Click Export.
3. Select the sheet.
4. Click Export.
5. Name the exported file and select the location to save it in, then click Save.
6. A message will indicate when the export is done. Click OK.

Note: When exporting a sheet with an image, the image will not export with the xml. You must have a copy of the image to include when you import the xml later on.

Consent Form Layout
In **Sheets** (1123), double-click on a consent form.
Consent forms support Electronic Signatures (306).
To create a consent form for a patient, see Consent Form (395).
Consent forms can be sent to the eClipboard when Mobile Layout (1127) is enabled.

1. In the Main Menu (592), click Setup, Sheets.
2. Copy a sheet with a Consent type, or create a new one.
   - Highlight an internal Consent sheet and click Copy.
   - Highlight a custom Consent sheet, then click Duplicate to copy it.
   - Click New to create a new custom sheet and select Consent as the type.
   - Double-click an existing custom Consent sheet to edit.
3. Change the sheet as desired.
   Sheet Def Properties (1129)
   Sheet Field Types (1130)
4. Click OK to save.

Deposit Slip Layout

In Sheets (1123), double-click on a deposit slip.

Only the top-most deposit slip in the list of custom sheets will be used for printing. If no custom deposit slips exist, the internal deposit slip is used. To generate a deposit slip, see Deposit Slip (516).

The internal (default) deposit slip is designed to print onto preprinted QuickBooks forms. These can be ordered from many different suppliers. The top third gets torn off and includes preprinted bank account information and room for up to 18 deposit items. The bottom 2/3 is a detailed report to be kept by the dental office that includes deposit date, total, and a list of items.

To customize print layout, create a custom sheet with a DepositSlip type.

1. In the Main Menu (592), click Setup, Sheets.
2. Copy a deposit slip or create a new one.
   - Highlight the internal deposit slip and click Copy.
   - Highlight a custom DepositSlip, then click Duplicate to copy it.
   - Click New to create a new custom sheet and select DepositSlip as the type.
   - Double-click an existing custom DepositSlip to edit.
3. Change the deposit slip as desired, then click OK to save.

You must add the cashSumTotal output field for cash payments to be included on QuickBook laser forms.

Also see: Sheet Def Properties (1129) and Sheet Field Types (1130).
OutputText fields:

- **cashSumTotal**: The total sum of cash payments. Cash payments must have a payment type of *Cash* associated to calculate.
- **CheckNumber01 - CheckNumber18**: Each deposit item may have a check number attached. Up to 18 check numbers may be associated with deposits.
- **deposit.BankAccountInfo**: The bank account information as entered on the Edit Practice window or, if using Clinics, Edit Clinic window. Practice Setup(931), Clinic(1224)
- **deposit.DateDeposit**: The date of the deposit as entered on the Edit Deposit Slip window.
- **depositList**: A list of all deposit line items. About 32 line items can fit on an internal deposit slip. However you can customize the slip to include as many line items as fits on one sheet of paper by removing the deposit items and moving the depositList higher on the sheet. For Growth Behavior, choose Down Global so the field auto-grows based on output. Note that the deposit slip will only be one page, regardless of the number of line items.
- **depositTotal**: The total dollar amount included in the deposit.
- **depositItemCount**: The total count of all deposit items on the slip.
- **depositItem01 - depositItem18**: Each deposit item represents one deposit line item. There are only 18 possible deposit items. To create a deposit slip that allows more than 18 items, use the depositList field instead and remove all deposit items from the sheet.

**ERA Layout**

In **Sheets(1123)**, double-click on ERA.
To only print one ERA page per claim, enable the preference for **ERAs print one page per claim** in the **Manage Module Preferences** (744).

1. In the **Main Menu** (592), click Setup, Sheets.
2. Copy a sheet or create a new one.
   - Highlight the internal ERA sheet and click *Copy*. Then double click the custom ERA.
   - Click *New* and create a new sheet with a ERA type.
   - Double click an existing custom ERA to edit it.
   - Highlight an existing custom ERA then click *Duplicate* to copy it.
3. Change the sheet as needed.
   - **Sheet Def Properties** (1129)
   - **Sheet Field Types** (1130)
4. Click OK to save.

- **Note**: Do not place any fields below the ERA Claims Paid grid.
- The **ERAGridHeader** will show above every claim paid on an ERA.
- The **ERAGridHeader** should be edited separately on it’s own sheet. See **ERA Grid Header Layout** (1160).
In Sheets(1123), double-click an ERA header.

The ERAGridHeader shows above every claim paid on a customized ERA Sheet(1159).

Copy a sheet or create a new one.
- Highlight the internal ERAGridHeader sheet and click Copy. Then double click the custom ERAGridHeader.
- Double click an existing custom ERAGridHeader to edit it.
- Highlight an existing custom ERAGridHeader then click Duplicate to copy it.

Change the sheet as needed.
- Sheet Def Properties(1129)
- Sheet Field Types(1130)

Click OK to save.

Exam Sheet Layout
In Sheets(1123), double-click an exam sheet.
To generate exam sheets for a patient, see Exam Sheet(397).

1. In the Main Menu(592), click Setup, Sheets.
2. Copy a sheet or create a new one.
   - Highlight the internal Exam Sheet sheet and click Copy. Then double click the custom sheet.
   - Click New and create a new custom sheet with an ExamSheet type.
   - Double click an existing custom sheet of ExamSheet type to edit.
   - Highlight an existing custom sheet of ExamSheet type, then click Duplicate to copy it.
3. Change the sheet as needed.
   Sheet Def Properties(1129)
   Sheet Field Types(1130)

Some options on exam sheets can be used in patient letters. See Patient Letter Layout(1172).
- Radio Button groups with reportable names (Sheet Checkbox and Radio Button(1138))
- misc Checkboxes with reportable names
- misc Input Fields with reportable names (Sheet Input Field(1135))
- Output Text Fields (Sheet Output Text Field(1131))

4. Click OK to save.

Lab Slip Layout
In Sheets(1123), double-click a Lab Slip.
Lab slips for a Lab Case (379) are a type of Sheet and can be customized. This is typically done by scanning the slip provided by the dental lab and using it as a background image. Other required elements are placed on top, such as instructions, due date, and license number. Lab slips support Electronic Signatures (306).

To set a default slip for a dental lab, see Laboratories (918).

To create a lab slip for a patient, see Lab Slip (381).

Change the sheet as needed.

Sheet Field Types (1130)

Sheet Def Properties (1129)

Click OK to save.

Label Layout
In **Sheets** (1123), double-click a label.

- **LabelPatient**: Prints patient information.
- **LabelCarrier**: Prints insurance carrier information.
- **LabelReferral**: Prints referral information.

Open Dental has 9 internal label sheets. Labels can be customized by changing an internal sheet or creating a new custom label. To print a single label, see **Labels** (1708). This table has been omitted.

To customize a label, create a custom sheet with the correct type.

1. In the **Main Menu** (592), click Setup, Sheets.
2. Copy a label or create a new one.
   - Highlight an internal Label and click **Copy**.
   - Highlight a custom Label, then click **Duplicate** to copy it.
   - Click New to create a new custom sheet and select the correct Label type.
   - Double click an existing custom Label to edit.
3. Change the label as desired, then click OK to save.

**Sheet Def Properties** (1129)

**Sheet Field Types** (1130)
Assign a Label to the Toolbar Label Button
By default, when Label is clicked in the Main Toolbar(1649), the internal Label Patient Mail prints. To change the label that is printed:
1. In the main menu, click Setup, Sheets.
2. On the Sheet Def window, click the dropdown for Label assigned to patient button and select the label. Default refers to the internal Label Patient Mail. If custom labels exist, they will be options.
3. Click OK to save.

Medical History Layout
In Sheets(1123), double-click a medical history sheet.
Medical histories are a type of Sheet that can be customized. Patients can fill them out on a computer (e.g. in an operatory), via a Kiosk, eClipboard, or online using an internet browser (see Web Forms Feature). If InputFields are setup on the medical history, then entered data can be imported into the database.

- Patient Forms (1690)
- Import Patient Forms and Medical Histories (1692)

Before use, review internal sheets carefully and customize for your practice. Medical history sheets use special input and checkbox fields for medications, allergies, and problems. The internal sheets are only examples and may contain allergies and problems that do not exist in your Open Dental lists.
Three internal sheets have a type of Medical History.

- **Medical History Simple**: Patients enter information in text fields. Staff enters into Open Dental.
- **Medical History New Patient**: Patients check boxes and enter text in input fields that can be imported into the database.
- **Medical History Update**: Patients check boxes and enter text in input fields that can be imported into the database and compared to current values.

It is important that your master Medication, Allergy, and Problem lists do not contain duplicates. Each input field and checkbox on a medical history sheet corresponds to a specific item in the master list. When importing, spelling is compared to find matches. If exact matches are not found, import will not work properly. For example, if the allergy on the medical history is attached to 'Penicillin', but the patient's medication list contains *Pen*, the allergies will not match and the import will not work.

Sheet Def Properties (1129)

Sheet Field Types (1130).

Note: Medication, problem, and allergy input fields and checkboxes require special setup. See below.

**Medications**

Input fields and checkboxes fields can be used independently or together for medications.

Mark any medications that you are no longer taking and add any new ones:

- [ ] Ibuprofen
- [ ] Penicillin

Patients will enter medication names in InputFields (inputMed##). Up to twenty inputMed fields are allowed on a sheet. Each inputMed# can be only used once on a single sheet. Also see Sheet Input Field (1135).

- For new medications: Patients can type any new medications into the input field.
- For medication updates: If a patient's medication list contains a medication that matches an inputMed# field value, the field will automatically populate with the current medication. Patients can overwrite the entry if desired.

To add an input field:

1. On the Edit Sheet Def window, click InputField.
2. Select an inputMed# field that is not currently in use, enter its properties, then click OK. Each inputMed field can only be used once on a sheet. 

*Note: Web Forms Feature* will not populate inputMed fields automatically.

Checkboxes can be used with InputFields as No indicators. This is useful for Medical History Updates so a patient can indicate if they are no longer taking a medication. Since current medications automatically populate the input field, patients just need to indicate if they are no longer taking the med. See [Sheet Checkbox and Radio Button](1138).

Make sure the static text instructs the patient that the checkboxes indicate No.

To add a checkbox:
1. On the Edit Sheet Def window, click Checkbox.
2. Click on the checkMed# field that corresponds to an inputMed# field (e.g. checkMed1 corresponds to inputMed1).
3. Click OK.

Importing: When you import medications into the database, medications manually typed in by the patient are always treated as new medications, regardless if the checkbox is marked.

**Allergies and Problems**
Checkboxes can be used as yes/no indicators for allergies and problems. If allergies are already entered in a patient's record, the checkbox will automatically be marked on the medical history form.
1. On the Edit Sheet Def window, click Checkbox.

2. Select the allergy or problem field name. The Allergies or Problems list will display items entered in your master Allergy List (1221) and Problem List (1250). If you are editing a Checkbox linked to an Allergy or Problem missing from the master lists, a prompt will display to add them. Click yes to create the new Allergy or Problem.
3. Click on the allergy or problem this checkbox applies to. Click the **Add Allergy/Add Problem** button to add new items to the master lists of each. See **Allergy List** and **Problem List** for details on adding each.

4. On the right, select whether the checkbox indicates yes or no. You can create all yes boxes, or, typically you will create both a yes and a no box for each allergy/problem, and they will be linked together. This will cause them to toggle as a radio button, meaning there can be only a yes or no answer, not both.

5. Click OK.

6. Add a static text field next to the checkbox to label it.

Important: If a problem or allergy is renamed in the master Allergy or Problem lists, make sure to change all medical history sheets that use the allergy/problem. Simply open each medical history sheet, double click on the pertinent check boxes, and select the new allergy/problem. If spelling is inconsistent, then importing will not work properly.

**Patient Form Layout**

In **Sheets**, double-click a patient form.
When a patient fills out a patient form, data entered into InputFields, or in checkboxes/radio buttons associated with InputFields, can be imported into the Open Dental database. This is useful for registration forms, HIPAA agreements, financial agreements, etc.

- **Patient Forms** (1690)
- **Import Patient Forms and Medical Histories** (1692)

Several internal sheets have a type of *PatientForm*. They can be customized or you can create new ones.

1. In the **Main Menu** (592), click Setup, Sheets.
2. Copy a sheet or create a new one.
   - Highlight an internal PatientForm and click **Copy**. Double click the custom sheet to open.
   - Click **New** to create a new custom sheet with a PatientForm type.
   - Double click an existing custom PatientForm to edit.
   - Highlight an existing custom PatientForm, then click **Duplicate** to copy it.
3. Change the sheet as needed.

**Sheet Def Properties** (1129)

**Sheet Field Types** (1130)

4. Click OK to save.

**Patient Letter Layout**

In **Sheets** (1123), double-click a patient letter.
At least one custom sheet with a type of PatientLetter must exist before a patient letter can be generated. To create or send letters, see Letter(1678).

1. In the Main Menu (592), click Setup, Sheets.
2. Copy a sheet or create a new one.
   - Highlight the internal Patient Letter sheet and click Copy. Then double click the custom sheet.
   - Click New and create a new custom sheet with a PatientLetter type.
   - Double click an existing custom sheet of PatientLetter type to edit.
   - Highlight an existing custom sheet of PatientLetter type, then click Duplicate to copy it.

3. Change the sheet as needed.

   Sheet Def Properties (1129)

   Sheet Field Types (1130)

For patient letters only, you can insert a field from a custom exam sheet within a Static Text Field.

4. Click OK to save.

Including Pre and Post Treatment Images in a Patient Letter

Here is an example of how you might include patient images (Pat Images) in this type of sheet. To use multiple patient images, save each image in a separate Images category because only the first image in each category is pulled.
Payment Plan Layout

In Sheets(1123), double-click on a Payment Plan.
The layout of printed Payment Plan (239) terms (Sign and Print Payment Plan (243)) can be customized by setting up a sheet with a Payment Plan type. If enabled, the same custom sheet is used for all printed payment plans.

**Enable the Preference**
Enable the preference in Account Module Preferences (693).

In the Main Menu (592), click Setup, Account, Misc Account tab. Check the option **Pay Plans use Sheets**.

The custom payment plan sheet listed first alphabetically will be used. For example, if two custom payment plans named Plan A and Plan B exist, Plan A will be used because it comes first alphabetically. If there is no custom payment plan, the internal sheet will be used.

Uncheck the preference to use the classic payment plan layout instead.

**Set up a Payment Plan Sheet**
Copy a sheet or create a new one.
- Highlight the internal Payment Plan sheet and click Copy. Then double click the custom statement.
- Click New and create a new sheet with a Payment Plan type.
• Double click an existing custom payment plan to edit it.
• Highlight an existing custom payment plan then click *Duplicate* to copy it.

Change the sheet as needed.
• **General Sheet Properties** (1129)
• **Sheet Elements** (1130)

• Note: There is one grid, PayPlanGrid, that is only available for sheets with a PaymentPlan type. The columns in the grid are fixed and cannot be changed. **Sheets: Grids** (1147)
• An electronic signature box can be added to a payment plan sheet. If added, a preview window will display before printing so the plan can be signed. **Sheets: Signature Boxes** (1143)
• Printed and saved custom payment plan terms are saved as PDFs in the Images module. To set the folder these payment plans are saved in, see **Definitions: Image Categories** (869).

**Screening Layout**

In **Sheets** (1123), double-click a Screening.
Screening forms used during Public Health Screenings (1457) can be customized using sheets. Also see Public Health Custom Screening (1462).

- Note: For custom screening sheets to be available, enable Screenings use sheets in Chart Module Preferences (706).
- If there are no custom screening sheets, the internal sheet will be used.

**Customize the Screening Sheet**

Copy a screening sheet or create a new one.

- Highlight the internal Screening sheet and click Copy. Then double-click the custom screening.
- Click New and create a new sheet with a Screening type.
- Double-click an existing custom screening to edit it.
- Highlight an existing custom screening then click Duplicate to copy it.
Change the sheet as needed, then click OK to save. Refer to Sheet Def Properties(1129) and Sheet Field Types(1130) for details.

Useful Screening Elements:

**Checkboxes** (1138): When using checkboxes in a screening, you can add additional procedure codes to chart automatically. At the bottom of the Edit Checkbox window, click Add, then select from the list of procedure codes. The following checkboxes are defaulted on the internal screening sheet.
- **Assessment Proc checkbox**: If checked during a screening, a completed procedure for code D0191 (assessment of a patient) will be added to the patient's chart.
- **Fluoride Proc checkbox**: If checked during a screening, a completed procedure for code D1206 (topical application of fluoride varnish) will be added to the patient's chart.

**ComboBoxes** (1144): Pick lists that allow the screener to select one option from a list of choices. Five combo boxes exist on the internal screening sheet: Gender, Place of Service, Urgency, Race/Ethnicity, and Grade Level. Options can be reordered, added, or removed.

**ScreenCharts** (1146): Tooth charts of posterior teeth. Two tooth charts are available and each can be set for primary or permanent teeth:
- **ChartSealantTreatment**: To mark current tooth status including treatment needed.
- **ChartSealantComplete**: To mark sealants that are complete.

Double-click on a chart to set the teeth to permanent or primary.

When sealant code is entered (S) to a chart with permanent teeth, a matching sealant procedure is added to the patient's chart with the corresponding status. Below is ChartSealantTreatment tooth chart as it looks during a screening. Simply click on a tooth or surface to select a code.

![ChartSealantTreatment](chart.png)

Referral Letter Layout

In Sheets(1123), double-click a referral letter.
Before creating or sending a letter to a referral, you must set up at least one custom sheet with a type of ReferralLetter.

Also see Referral Letter(1681).

In the MainMenu(592), click Setup, Sheets.

Copy a sheet or create a new one.
- Highlight the internal Referral Letter sheet and click Copy. Then double click the custom sheet.
- Click New and create a new custom sheet with an ReferralLetter type.
- Double click an existing custom sheet of ReferralLetter type to edit.
- Highlight an existing custom sheet of ReferralLetter type, then click Duplicate to copy it.

Change the sheet as needed.
Sheet Def Properties(1129)
Sheet Field Types(1130)

Note: The tooth chart and tooth chart legend can be added to the Referral Letter by clicking Special. See Sheet Special Field(1149).
Referral Slip Layout

The referral slip sheet is used for patient and provider referrals.

In Sheets(1123), double-click a referral slip.

The internal referral slip sheet shown above is the default referral slip. Create additional referral slip sheets for different referral sources. Assign the custom sheet to a referral source from the Referral List(1268). If multiple sheets are created, only the internal ReferralSlip sheet type in the sheets list is used unless a different sheet is selected before attaching a referral to a patient, see Referral Slip(79).
To customize or create a new *ReferralSlip* sheet type, see *Edit Sheet Def*(1125). Referral slips support *Electronic Signatures*(306) and can be added to the sheet.

Routing Slip Layout

Customize the information printed on routing slips for scheduled appointments.

In *Sheets*(1123), double-click a routing slip.

![Routing SlipLayout](image)

To print the customized sheet, see *Routing Slips*(1302).

To add or edit a routing slip sheet, double-click an existing routing slip or click Add to create a new slip. Add or edit the *Sheet Field Types*(1130) as needed then click OK to save.

Rx Layout

In *Sheets*(1123), double-click an Rx.
See Sheet Def Defaults (1151) to set the sheet to use when printing a single Rx / Prescription (333).

In the MainMenu (592), click Setup, Sheets.

Copy an Rx sheet or create a new one. Also see Add or Customize a Sheet.
- Highlight the internal Rx sheet and click Copy. Then double click the custom sheet.
- Click New and create a new custom sheet with an Rx type.
- Double click an existing custom sheet of Rx type to edit.
- Highlight an existing custom sheet of Rx type, then click Duplicate to copy it.

Edit the sheet as needed. You should be able to handle any regulations imposed by your state. If for some reason you cannot, please contact us and we will add any additional options that might be needed.
- Remove various Lines, boxes, and wording so you can print to a preprinted Rx form.
- Add an Image.
- Change the orientation or size (Edit Properties).
- Change the wording for generic substitution (Static Text).
- Add a second signature line for generic substitution.
- Add an RxStateID field (OutputText: prov.stateRxID)
- Remove or move the X that is marked by default for Generic Substitution Permitted. The X is two diagonal lines
To remove the lines, delete them. To move the lines, select them, then press the up arrow on your keyboard (e.g. move to the Dispense as Written checkbox instead).

- Days of Supply and ProcCode show by default. To populate data, enable Procedure code required on some prescriptions preference in Lists, Prescriptions.
- For other options, see Sheet Field Types (1130).

If the state requires two signature lines (e.g. use generic and as written), this sheet template may help: rxtwosigs.xml. Right click on the file, save it, then Import it.

To customize a print layout for multiple prescriptions on one page, see Rx Multiple Layout (1184).

**Rx Instructions Layout**

Rx Instructions are a type of sheet that can be used to provide prescription instructions intended for the patient.

In Sheets (1123), double-click an Rx instruction sheet.
Change the sheet as needed. See Sheet Def Properties(1129), Sheet Field Types(1130).

To print this sheet for a patient click the Pat Instr. button in the Edit Rx(333) window. That is also where the specific instructions for each medication will be entered, in the Patient Instructions field.

This sheet can also be printed automatically with the PrintRxInstruction action using Automation(819).

Rx Multiple Layout
In Sheets(1123), double-click an RxMulti sheet.
See Rx Manage(337). By default, the internal RxMulti sheet is used but it can be customized.

1. In the MainMenu(592), click Setup, Sheets.
2. Copy a RxMulti sheet or create a new one.
   o Highlight the internal RxMulti sheet and click Copy. Then double click the custom sheet.
   o Click New and create a new custom sheet with an RxMulti type.
   o Double click an existing custom sheet of RxMulti type to edit.
   o Highlight an existing custom sheet of RxMulti type, then click Duplicate to copy it.
3. Edit the sheet as needed. For all options, see Sheet Field Types(1130).
   You should be able to handle any regulations imposed by your state. If for some reason you cannot, please contact us and we will add any additional options that might be needed.
   o Remove various lines, boxes, and wording so you can print to a preprinted Rx form.
   o Add a dentist license number (OutputText: prov.dEANum, prov.StateLicense, prov.NationalProvID).
   o Add an image.
   o Change the orientation or size (Edit Properties).
   o Change the wording for generic substitution (Static Text).
   o Add a second signature line for generic substitution.
   o Add an RxStateID field (OutputText: prov.stateRxID).
   o Remove or move the X that is marked by default for Generic Substitution Permitted. The X is two diagonal lines (Line:50,368,W:12,H:12 and Line:62,368,W:-12,H:12). To remove the lines, delete them. To move the lines, select them, then press the up arrow on your keyboard (e.g. move to the Dispense as Written checkbox instead).

Each Rx template requires a corresponding Prov.NameFL, PatNameFL, PatBirthdate, and Drug output text field.

Each Output Text(1131) field has a number to indicate its order on the page. For example, prov.nameFL is for prescription 1, prov.nameFL2 is for prescription 2, etc. Simply make sure the output text fields for each prescription match the order on the page. Prescription 4 should have output text fields that end in 4, prescription 5 should have output text fields that end in 5, etc.
The internal RxMulti sheet prints up to 4 prescriptions per page, but it can be customized to print up to 6. When printing multiple prescriptions, any unused Rx sheets will have VOID printed across them.

4. Click OK to save.

**Statement Layout**

In Sheets(1123), double-click a Custom Sheet.
**Statement** (269), **Invoice** (272), and **Receipt** (271) can be customized by setting up a **Sheet** (1123) with a Statement type. The same custom sheet will be used for all statements, invoices, and receipts, with only the title and relevant information changing depending on which document is generated.

**Set up a Statement Sheet**

The custom statement sheet listed first alphabetically in Sheets setup will be used. For example, if there are two custom statements named Custom Statement and Walkout Statement, Custom Statement will be used because it comes first alphabetically. If there is no custom statement, the internal sheet will be used.

Copy a sheet or create a new one.

- Highlight the internal Statement sheet and click *Copy*. Then double click the custom statement.
- Click *New* and create a new sheet with a Statement type.
- Double click an existing custom statement to edit it.
- Highlight an existing custom statement then click *Duplicate* to copy it.

Change the sheet as needed.

- **Sheet Def Properties** (1129)
- **Sheet Field Types** (1130)

There are additional options that are only available for sheets with a **Statement** type. A few are described below.

**Grids** (1147): There are five grids that can be added to a sheet.

- **StatementAging**: Fixed information, cannot be changed.
- **StatementEnclosed**: Fixed information, cannot be changed.
- **StatementMain**: Column names, order, and size can be changed in **Display Fields** (900), StatementMainGrid.
- **StatementPayPlan**: Fixed information, cannot be changed.
- **StatementInvoicePayment**: Fixed information, cannot be changed. The grid will populate with payments attached to procedures on the invoice as well as unattached payments that were made on the same day.
  - This grid shows payments attached to procedures and payments made on the same day that are not attached to procedures. Changing a payment overrides the original amount on the invoice.

**Payment Options**: When adding **Static Text Fields** (1133), there is an additional 'Is Payment Options' checkbox. When checked, this designates the field for inclusion when payment information is included in a statement, invoice, or receipt. The checkbox 'Hide payment options' on the Statement window determines if payment information is included or not.

**Output Text Fields**: The fields below are especially useful for statements, invoices, and receipts. Also see **Sheet Output Text Field** (1131).

**accountNumber**: The guarantor's account number. Shows guarantor account number even if printing a statement for a different family member.

**billingAddress**: The guarantor's entire address as entered on the Edit Patient Information window. Patient vs guarantor name is determined by how the bill is generated. If via the Billing List, the guarantor name shows.

**invoicePaymentLabel**: This output field is labeled Payments in the sheet or Payments & Write-Offs if the Account Module preference, *Invoices’ payments grid shows write-offs* is checked.

**invoicePaymentValue**: This output field displays the payment amount. This is the sum of all the payments in the Patient Account grid, whether or not the payments are attached to a procedure. If the Account Module preference, *Invoices’ payments grid shows write-offs* is checked, the procedure write-off will be included in this value.

**invoiceTotalLabel**: This output field is labeled Balance Remaining in the sheet.

**invoiceTotalValue**: This output field displays the balance remaining amount. This is the sum of the charges minus the sum of the payments.

**invoicePayPlanLabel**: This output field is labeled Pay Plan Charges in the sheet.

**invoicePayPlanValue**: This output field displays the payment plan debit amount.
returnAddress: The physical practice address, or if using clinics, the physical clinic address.

statementReceiptInvoice: This field determines the title of the document based on how it is generated.
- Statements will read STATEMENT #.
- Receipts will read RECEIPT.
- Invoices will read INVOICE.
- For Australia and New Zealand, it will read TAX INVOICE.
- For Singapore it will read RECEIPT #.

statementIsCopy: If printing a copy of an invoice the word COPY will be printed on the sheet.

statementIsReceipt: Only shows when printing receipts. The field will show KEEP THIS RECEIPT FOR INCOME TAX PURPOSES.

statementURL: Include a URL patients can use to launch the Patient Portal Sign in window where they can view an online version of the statement and/or make a payment (e.g. http://www.patientview.com/statement/CyVue8). Online Payment Management(1563)

statementShortURL: Include a short version of the URL patients can use to to launch the Patient Portal Sign in window where they can view an online version of the statement and/or make a payment (e.g. http://od.ag/s/CyVue8).

ProviderLegendAUS: This output field only works for users in Australia, with language settings set to English-Australia. Adds a legend to the statement that shows all non-hidden providers.
- Swiss bank routing fields do not show on the new custom statements.
- Australian Provider legend must be added from the available output fields.

statement.Note/statement.NoteBold: These output fields are drawn from Dunning Messages(513).

Treatment Plan Layout
In Sheets(1123), double-click a Treatment Plan.
Note: The custom Treatment Plan (283) sheet listed first alphabetically will be used. If there is no custom treatment plan, the internal sheet will be used.

Example: If there are two custom treatment plan sheets, Custom Treatment Plan and Treatment Plan 2, Custom Treatment Plan will be used because it comes first alphabetically.

**Customize a Treatment Plan Sheet**

In the Main Menu (592), click Setup, Sheets. From here copy a treatment plan sheet or create a new one.
* Highlight the internal Treatment Plan sheet and click Copy. Then double click the custom treatment plan.
* Click New and create a new sheet with a Treatment Plan type.

If you have already created a custom treatment plan to edit:
* Double-click an existing custom treatment plan to edit.
* Highlight an existing custom treatment plan then click Duplicate to copy it. Double-click the new copy to edit.
Use the links below for useful information as you customize the sheet:

- **Requirements**: A treatment plan sheet must have exactly one signature box. It also must have at least one TreatPlanMain Grid(1147).
- See Sheet Def Properties(1129) to edit the sheet name, font defaults, width/height, and page orientation.
- See Sheet Field Types(1130) for additional details on customizing other sheet elements.

Certain options are only available to sheets with a Treatment Plan type. They are listed below:

- Tooth chart and tooth chart legend: These are Special Fields(1149).
- TreatPlanMain grid: The Grid(1147) between the tooth chart legend and Family Insurance Benefits. At least one of this grid type must exist on a treatment plan sheet. The columns, header, width and order are determined in Display Fields(900), TreatmentPlanModule.
- TreatPlanBenefitsFamily grid: Family Insurance Benefits grid
- TreatPlanBenefitsIndividual grid: Individual Insurance Benefits grid
- SignatureText: OutputText where patient may type their name.
- SignaturePracticeText: OutputText where presenter may type their name.
- DateTSigned: Records date of electronic signature.
- DateTPracticeSigned: Records date of second electronic signature.
- SigPractice: Secondary Signature box, where presenter may sign if desired.

Note: In order for the second signature box to prompt when clicking Sign TP, the custom Treatment Plan sheet needs to include both the SigPractice box, and the SignaturePracticeText box as an Output Text Field(1131).

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**Sheet Troubleshooting**

The following information may be useful when using Sheets(1123).

**I accidentally deleted a custom sheet. How can I recover it?**

To recover it you will use a backup copy of the database that does contain the sheet:

1. Restore a Backup copy of the database.
2. In the Main Menu(592), click Setup, Sheets.
3. Highlight the custom sheet, then click Export. Save the file. It will be saved as a .xml file.
4. Close the backup database, then open the current database.
5. In the Main Menu, click Setup, Sheets.
6. Click Import, then select the xml file saved from the backup.

**I can't freehand draw on my sheet.**

To enable freehand drawing on the sheet, the sheet must have a large enough image covering the entire drawing area. If you do not insert any images, then Open Dental automatically adds an invisible white dummy image that is used for drawing. If you insert an image, it must be large enough to cover the entire background, or you must insert a second image that does. If you do not, you may inadvertently disable drawing on the rest of the sheet.

**Blank pages are printing.**

Blank pages indicate that there is a field, image or element on the page. Make sure that no fields, elements or images extend outside of the page. Check for blank images, white images, too large fields, blank text boxes, etc. Then, move the item or change its properties.

**On Web Forms, mysterious fields are showing, but I don’t see anything in the Sheet preview.**

If fields are showing, they are on the sheet but perhaps outside of page left or right margins. On the Edit Sheet Def window, locate the item in the Fields list on the right, then double click to change its properties.

**On Web Forms, the fonts are not showing correctly.**

Font support is dependent on the browser used to view the Web Form. If a browser doesn't support a font, a different font will be substituted. This can affect layout of the sheet. We recommend using common fonts (e.g. Times New Roman, Arial, Courier) and testing sheets on a browser and device you plan to support. Static text fields in particular may need to be larger to fit text.
An image on my sheet isn't showing.
This means the computer you are printing the sheet from can't find the image in the OpenDentImages folder. Static Images should be in the SheetImages folder; patient images should be in the folder selected for Pat Image in Definitions, Image Categories.

On custom treatment plan, the column headers in the TreatPlanMain grid are blank.
Column header are determined in Display Fields, TreatmentPlanModule, by the entries for New Descript. By default these values are blank. To create headers, simply enter the text you want to show. This text also changes the column headers in the Treatment Plan module.

Patient is getting a Must enter valid value for required field error when entering birthdate. Practice uses multiple Web Forms.
Verify that the birthdate is entered on each form before submitting.

Spell Check
A custom dictionary can be created for words or abbreviations not commonly known.
In the MainMenu(592), click Setup, Spell Check.

Spell Check Enabled: Enable spell check to underline misspelled words throughout the program.
Note: This preference will be disabled if Text boxes use foreign language Input Method Editor (IME) composition is checked in Miscellaneous Setup(921).

Add: Enter a custom word or abbreviation, then click Add to add it to your dictionary. The custom dictionary is stored in the database and shared, so it is available on every computer in the office.
Double-click an existing word to edit it.
Using Spell Check

Text Boxes (319) throughout the program have spell checking built in. Words flagged as possible misspellings are underlined in red. When you see a red underlined word, right-click on it.

Select the appropriate action:
- Replace the word with a Hunspell generated suggestion.
- Add the word to the custom dictionary.
- Disable spell checking. If Disable Spell Check is selected, spell checking will remain disabled for the entire office until a user with the Security permission for Setup re-enables the Spell Check option.

Technical Details

We make use of the open source Hunspell spell checker and morphological analyzer. Hunspell is the spell checker of LibreOffice, OpenOffice.org, Mozilla Firefox &amp; Thunderbird, and GoogleChrome as well as other proprietary software packages.

Tasks Preferences

Task preferences let you customize global task settings, local computer default settings, and set up task inboxes.

In the Main Menu (592), click Setup, Tasks (1695).
Global settings

Inbox Setup: Set up user inboxes. See Task List and Inbox(1705).

Show legacy repeating tasks: This is checked by default if repeating tasks existed prior to updating to 16.3. Otherwise the box is unchecked by default. See Repeating Task Lists (Legacy)(1703).
- Checked: The repeating task list tabs will show in the Tasks Area. Checking this box will disable reminder tasks.
- Unchecked: Repeating task lists do not show.

Always show task list
- Checked: The Tasks area will be docked at the bottom or to the right of the screen in all modules. The Local Computer Default Settings will be enabled.
- Unchecked: The Tasks area can only be accessed via the Manage module, Tasks.

New/Viewed status tracked by individual user
- Checked: Users can independently mark tasks as viewed/not viewed without affecting others. This is useful when task lists are used heavily. For user inboxes, the new message count applies to the user the inbox is assigned to, not the currently logged on user. For all other task lists, the new message count applies to the currently logged on user only.
- Unchecked: The new/viewed status will be the same for everyone.

Show open tasks for user
- Checked: The Open Tasks tab will show in the Tasks area.
- Unchecked: The Open Tasks tab will not show in the Tasks area.

Default to sorting appointment type task lists by AptDate Time: Set the sort order for Tasks Lists that have an object type of appointment. To change this setting for the current user only see Tasks, Options button.
- Checked: Task lists that have an appointment Object Type will sort tasks first by the attached appointment's date and time, then by all other object types.
- Unchecked: Task lists that have an appointment Object Type will sort tasks by the task creation date and time.

Global Filter for Task Lists: Only available when Clinics(1505) are enabled. Allows users to filter the task list by the clinic associated with the patient or appointment on the task.
- Disabled: Do not enable task filtering.
- None: Enable task list filtering but do not automatically filter.
- Clinic: Enable task list filtering and default to filter by the selected clinic.
- Region: Enable task list filtering and default to filter by region. See Definitions: Regions(889). A region must be assigned to each Clinic(1224).

**Local computer default settings**
These options will affect the current workstation only.

**Don't show on this computer**
- Checked: Tasks lists will not show on this computer.
- Unchecked: Tasks lists will show based on the global setting for Always show task list.

**Dock Right / Dock Bottom:** Determines where the Tasks area is docked when set to show in all modules.
- Dock Right: The Tasks area will be docked on the right side of the screen. Enter an X Default value to set the default location of the vertical splitter.
- Dock Bottom: The Tasks area will be docked across the bottom of the window. Enter a Y Default value to set the default location of the horizontal splitter.

**Quick Letters**
In the MainMenu(592), click Setup, Obsolete, Letters.
Your existing Quick Letters will be listed here. The Quick Letters tool has been superceded by Sheets (1123).

**Questionnaire**

This feature is obsolete, and has been replaced by Patient Form and Medical History Sheets (1123).

However, since it is too time consuming to create a sheet with multiple checkboxes on it, we are going to leave the questionnaire feature in place for a while in case someone is still using it. To enable, see MainMenu (592), Setup, Advanced, and click Show Features (806). A Questionnaire button will show in the Account Module (150) toolbar.

**Procedure Codes**

In the MainMenu (592), click Lists, Procedure Codes.
Alternatively:
- Press Ctrl+Shift+F.
- In the Chart Module (298), click Procedure List.

Note: During the Trial installation, temporary (T) codes are installed. When you first update to the full version of Open Dental, you will need to remove these T codes. At the lower left, click Tools (1198).

The Procedures grid lists procedure codes that exist for the highlighted categories. Fees for up to three fee schedules can be viewed at a time, each represented by a Fee column (Fee 1, Fee 2, Fee 3). The criteria set under Compare Fee Schedules determines the fees that show.

To enter fees, click in a Fee column cell. Press tab to quickly move from cell to cell.

Double-click a row to edit the Procedure Code (1200).

**Search**
- **Search**: Search the selected category(s) for a procedure code. As you enter text the list will update with matching results.
- **By Abbrev**: Search by procedure code abbreviation.
- **By Descript**: Search by description text.
- **By Code**: Search by code.
- **Sort Order**: Choose a sort order for procedure codes. Sort by Category or Procedure Code. Set the default in Chart Module Preferences (706).
**By Category:** The highlighted categories determine which procedure codes show in the grid. To select all categories click All.

Click **Edit Categories** to customize categories and sort order. See Definitions: Proc Code Categories(883).

**Show Hidden:** Check to show or hide categories marked as hidden. Click default to set the current setting as the default. Note: This option is only available when the Procedure Codes window is accessed via Lists, Procedure Codes.

**Procedures**

**Procedures:** A list of all procedure codes that exist for the selected category. Procedure fees for up to three fee schedules may also show, depending on the criteria set under Compare Fee Schedules.

**Fee Schedules**

See Fee Override for Provider or Clinic(1206)

See Fee Schedule Logic(1209)

**Compare Fee Schedules:** Select the criteria that determines which fee columns and fees show in the Procedures grid.

**Fee Schedule:** Click the dropdown or [...] to select the fee schedule.

**Clinic:** To view or enter fees specific to a clinic, click the drop down or [...] to select the clinic. If a user is restricted to a clinic, they will only be able to view fees for the clinic they are restricted to.

**Provider:** To view or enter fees specific to a provider, click the drop down or [...] to select the provider. Note: Clinic and Provider are only enabled if the fee schedule allows provider and/or clinic-specific fees (Use Global Fees is unchecked).

**Fee Colors:** The fee color is a quick method of identifying whether a fee is global or provider and/or clinic-specific. The default colors are listed below. Customize fee colors in Definitions: Fee Colors(868).

- Black: A global fee.
- Orange: Clinic-specific fee.
- Green: Provider-specific fee.
- Blue: The fee is specific to a provider and clinic.

**Fee Scheds:** Create Fee Schedules(914).

**Fee Tools:** Copy, export or import fees, increase fees by a percentage, or update fees for treatment planned procedures. See FeeTools(1210).

**Procedure Codes**

(buttons at lower left)

**Import/Export:** Import or export procedure codes in an XML format. If exporting, only codes currently showing in the grid are exported. When importing, only codes that do not yet exist in the database will be imported. Existing codes will not be edited. To import/export fees, see Fee Tools(1210).

Note: It is a violation of the copyright to share CDT codes with another office. However non-CDT codes and other types of codes (e.g. for Foreign Countries) can be exported then imported to other databases.

**Tools:** Launch Procedure Code Tools(1198) to remove temporary codes, update CDT codes, add missing D or N codes, and/or reset default auto codes, procedure buttons, appt proc quick adds or recall types. Buttons are only visible to users with the Setup permission.

**New:** Add Procedure Code(1204) (e.g non-CDT codes or codes used in another country).

Note: Some areas are only available or viewable to users with the "Setup" Permission(1118).

**Enter Fees via the Procedure Code List**

To quickly enter fees in a fee schedule, use the Procedure Code List.
1. Highlight the procedure categories to show in the Procedures grid.
2. Under Compare Fee Schedules, select the fee schedule(s) that you want to enter fees for. Up to three fee schedules can be selected at a time. If a fee schedule allows fees that are provider and/or clinic specific, both the clinic and provider options will be available. As you select criteria, the Fee 1, 2, and 3 columns will update with the current fees.
   - Fee Schedule: Click the dropdown or [...] to select the fee schedule.
   - Clinic: To enter fees specific to a clinic, click the drop down or [...] to select the clinic.
   - Provider: To enter fees specific to a provider, click the drop down or [...] to select the provider.
3. Click in a fee column and enter the fee. Press tab to quickly move from cell to cell for quick data entry.
4. When finished, click Close to save the fees and close the window.

Questions and Answers

How do I print fee schedules?
Print the Procedure Codes - Fee Schedules Report (1361).

Procedure Code Tools
In Procedure Codes (1195), at the lower left, click Tools.

Procedure Code Tools should be run in the following situations:
- Immediately after updating to the full version from the trial version. The trial version comes with T (temp) codes instead of D codes. Check all boxes to remove the T codes, add missing D and N codes, and reset defaults. See Update to Full Version.
- To reset default auto codes, recall types, procedure buttons, and/or appt proc quick add procedures.
- To update CDT Codes each calendar year.
Note: Use caution when selecting and running tools so you do not accidentally reset customized autocodes, procedure buttons, appt proc quick adds, or recall types. The Security Admin Permission is required to run procedure code tools.

Check the box next to the tools you want to run. Uncheck a box to deselect a tool.

**T codes:** Remove all temp codes (T) that were installed with the Trial version.

**N codes:** Add missing no-fee procedure codes.

**D codes:** Add missing CDT codes and set descriptions to the defaults. CDT codes that are no longer in use will remain in their existing categories.

Note:
New CDT codes are periodically released by the American Dental Association and generally released in Open Dental version updates at the beginning of the appropriate year. CDT codes are only available for distribution in the U.S.

- 2019 CDT Codes: Version 18.2.47 or 18.3.26 or greater
- 2018 CDT Codes: Version 17.2.36 or 17.3.22 or greater
- 2017 CDT Codes: Version 16.3.19 or greater
- 2016 CDT Codes: Version 15.3.37 or greater
- 2015 CDT Codes: Version 14.3.12 or greater
- 2014 CDT Codes: Version 13.2.22 or greater
- 2013 CDT Codes: Version 12.4.32 or greater

**Autocodes:** Delete all existing auto codes and reset the default Auto Codes(813). Procedure buttons will be dissociated from the deleted auto codes.

**Procedure Buttons:** Delete all existing procedure buttons, then add the default Procedure Buttons(736). This will not reset custom buttons in the Quick Buttons category.

**Appt Procs Quick Add:** Reset the list of Quick Add procedures on the Edit Appointment(20) to defaults.

**Recall Types:** Reset default Recall Types(635) and triggers. Any trigger T codes will be replaced with D codes.

Click Run Now to run all selected tools. A message will indicate when updates are done.

**Technical Details**
When running the D codes tool, the following changes occur automatically:
- New codes are added.
- Descriptions of existing codes are changed.
- Deleted codes are moved into the Obsolete category.

2013 Codes: When running the D codes tool for 2013 codes, the changes below also occur automatically.
- Insurance B benefits all changed to use D1208 instead of D1203/4.
- Recall setup fixed to use D1208, including both triggers and newly scheduled appointments.
- Changed all existing treatment planned D1203/4 procedures to D1208.
- Appt procs quick add, fluoride codes in that list changed to D1208.
- Proc buttons automatically change the fluoride codes to D1208.

**Troubleshooting**
**Problem:** I can't find my D1208 code.
Solution: Your Cleanings category might be hidden. In the Procedure Codes window, check the Show Hidden box, click All, then type D1208 into the By Code box. Either unhide the category in the Procedure Code List by clicking the Edit Categories button. Or else double click on the code (you must have Setup permission) and move the code to a different category. When you open the Procedure Code Edit(1200) window, hidden categories will not show, so the top-most category will be highlighted by default, and you can simply click OK to save the change.
**Problem: I already added D1208. What happens when I update?**
Solution: The update will not alter your existing D1208 code. All the other related automation will still happen automatically.

**Problem: I'm an eCW user. Do I really need to update Open Dental for 2013?**
Solution: No. Just manually add code D1208. This assumes that you send your claims from eCW. The main reason for updating Open Dental would be to get the new procedure descriptions. Insurance companies are being very picky about the procedure descriptions in claims. So if you don't send claims from Open Dental, the update is not important.

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**Procedure Code**
In Procedure Codes, double-click an existing code.

![Procedure Code](image)

**Time Pattern:** Use the vertical slider on the left to set the procedure time allotment. By default, each square represents 10 minutes. To change the default, see Time Increments in Appointment View Setup. Slash (/) indicates assistant time, X indicates provider time. Click X or / to toggle to the other. Procedure time is used to determine default appointment length. See Time Bars for more details.

**Proc Code:** The code itself. It can be up to 15 digits long. All codes starting with D will be shortened to 5 characters before being included on an insurance claim. For example, you can have two different codes for nitrous, with the difference...
being a letter that is added to the end of a standard D code. When sent to insurance, only the standard 5 digit code will be used.

**Note:** Once created, a code can’t be changed or deleted. Instead move it in an obsolete category.

**Alt Code:** Associate an alternate code. Useful for some Medicaid plans like Dental. See [Medicaid or Flat Co-Pay Insurance Plan](119).

**Medical Code:** Associate a medical code. The medical code must already exist. See [Cross Code](734). Cross coding only affects medical claims. It does not affect what shows on a an EHR CCD (summary of care).

**Ins Subst Code:** Associate an insurance substitution code and optionally set an Only if condition. The substitute code is used to calculate downgraded estimates for procedures (when insurance reduces the allowed amount of a procedure). See [Estimate Downgrades](137).
- Posterior composites: Typically enter the amalgam code and set the condition to Molar.
- Porcelain crowns: Typically enter the FGC code and set the condition to SecondMolar. If your office charges the same for both types of crowns this setting is not as important.

**Description:** Only non-ADA code descriptions can be edited. Automatically update ADA code descriptions using [Procedure Code Tools](1198).

**Abbreviation:** Can be edited.

**Layman's Term:** Enter simpler language to describe the procedure. It will show as the procedure description in [Treatment Plans](283), the [Chart Module](298), and the [Account Module](150).

**Base Units:** Typically for [Medical Insurance](128) claims. When calculating a procedure fee, the standard fee is increased based on the base unit, thereby increasing the billed fee. The base unit calculates the fee and time pattern using an additive process. Base Unit = 0 (standard fee) Base Unit = 1 (standard fee + standard fee) Base Unit = 2 (standard fee + standard fee + standard fee).

For example, the procedure code for Nitrous Oxide may have a time pattern of 15 minutes (base unit of 0) and a fee of $100. During the procedure, you may typically use Nitrous Oxide for a longer period of time. Instead of adding the procedure to the chart multiple times, increase the base unit.
- By setting the Base Unit to 1, the Time Pattern = 30 minutes and the Procedure Fee = $200
- By setting the Base Unit to 2, the Time Pattern = 45 minutes and the Procedure Fee = $300
- By setting the Base Unit to 3, the Time Pattern = 60 minutes and the Procedure Fee = $400

There is a checkbox on the [Insurance Plan](81) for **Claims show base units** which shows the base unit on the medical claim form.

**Drug NDC:** National Drug Code number.

**Default Revenue Code:** A 3-digit code sometimes used for institutional claims. It tells insurance where the patient was when they received insurance or the type of item they received. It will show as the default Revenue Code on the [Procedure - Medical Tab](314).

**Color Override:** Override the default color for this procedure on the [Graphical Tooth Chart](464). Usually colors are based on procedure status, such as Treatment Planned or Completed, not on individual procedure code. However in rare situations you may want a procedure code to always show in one color. For example, implants look better as always gray, instead of red, blue, or green. Click none to remove the override.

**Do not usually bill to Ins:** Determines the default setting of the Do Not Bill to Ins checkbox on the [Procedure - Financial Tab](312). Useful to identify procedures that are not usually sent to insurance (e.g. non-standard D codes, crown seats).
- Checked: Defaults the procedure to have the Do Not Bill to Ins box checked.
- Unchecked: Defaults the procedure to have the Do Not Bill to Ins box unchecked.

**Is Hygiene procedure:** See [Edit Appointment](20) for an explanation of Hygiene provider.
• Checked: This procedure will be automatically assigned to the hygiene provider when scheduling an appointment with two providers.
• Unchecked: This procedure will be assigned normally.

**Is Prosthesis:** Determines whether or not additional Prosthesis Replacement fields will show on the Procedure Info window.
• Checked: Prosthesis fields will show. Users must complete this information before sending the insurance claim.
• Unchecked: Prosthesis fields will not show.

**Is Radiology:** Typically used for EHR to designate a procedure as an x-ray.
• Checked: This procedure will considered a radiology order for EHR purposes.
• Unchecked: This procedure is not considered radiology for EHR purposes.

**Assign to Prov:** Assign a specific provider to this procedure. For example, create a procedure for selling mouthwash from the dental office, then assign the procedure to a dummy provider. This avoids inflated production numbers on real providers. The provider selected here will be assigned to this procedure when it is created and when it is set complete.

**Bypass Global Lock Date:** Determines whether or not this procedure will be affected by the Global Lock Date (if turned on).
• Checked: If this procedure has a $0 fee, it will not be limited by the global lock date, meaning it can be deleted or backdated. You can also add a new procedure and backdate it prior to the lock date, or backdate an existing procedure's procedure date to before the lock date. This can be useful for providers who add non-clinical procedures as reminders then later remove them.
• Unchecked: Global lock dates apply to this procedure as normal.

**Paint Type:** Determines how the procedure will be drawn on the Graphical Tooth Chart.
• Extraction: A large X when treatment-planned. Tooth is hidden when procedure is set complete.
• Implant: For any implant procedure code. It will frequently be a procedure you do in your own office, such as placing an abutment. To indicate a previously placed implant, assign this paint type to a surgical procedure with a status of EO. Before the implant graphic will show, the tooth must also be marked missing. Once an implant is showing, a crown can be entered. Crowns do not normally show on missing teeth, so entering an implant procedure first will be necessary in this case.
• RCT: Root canal graphics. A vertical line shows on teeth.
• PostBU: A graphic that fills the pulp chamber. Also used for pulpotomies (vital pulp therapies) on primary teeth. If you do lots of BUs that do not involve the pulp chamber, remove this paint type from the procedure code and use no paint type at all. Then the graphics will make better sense on the chart.
• FillingDark/Light: Dark and light color options.
• CrownDark/Light - Caps tooth. Tooth must be visible (or there needs to be an implant). Dark and light color options.
• BridgeDark/Light - Looks like a crown, but shows on both visible and missing teeth. Dark and light color options.
• DentureDark/Light: Teeth should be marked missing or hidden. Dark and light color options. Similar to crown graphic.
• Sealant: An S.
• Veneer: A graphic (inverted T) on the front of the tooth.
• Watch: A small W above or below the tooth.

**Treatment Area:** Determines the surface and tooth options available when charting the procedure ([Procedure](303)).
• Surf: Tooth and Surfaces.
• Tooth: Tooth only.
• Mouth: no extra options.
• Quad: UR, UL, LR, LL.
• Sextant: 1 - 6.
• Arch: U, L.
• Tooth Range: 1 - 32 or A - T.

**Category:** The category this procedure code will be grouped under. Customize category options in [Definitions: Proc Code Categories](883).
More: Click to view all fees, including provider and/or clinic-specific fees.

Audit Trail: All changes made to procedure fees are tracked in the audit trail. Click to view all Fee Changes.

Default Fees
At the upper right are the global fees for this procedure code, for each Fee Schedule(914).

Double-click on a row to change a fee amount.

Notes
Completed Note: Default procedure note that automatically copies to the Procedure Info window, Notes field when the procedure is set complete.

TP’d Note: The default Procedure Note that automatically copies to the Procedure Info window, Notes field when the procedure has a status of treatment planned. Does not work with procedures charted using the Make Recall button.

- Note: Use two quotes "" to remind staff to enter specific information in a note (Example: Due Date ""). If the information is not completed, a red Incomplete Note warning will appear above the note. To view a list of completed procedures with incomplete notes, see Incomplete Procedure Notes Report(1300). Other examples: composite shade, crown shade, denture shade, due date, blood pressure, nitrous levels, etc.
- To insert an Auto Note template in a Completed or TP'd Note, click Auto Note. If Procedures Prompt for Auto Note in Chart Module Preferences(706) is checked, opening the Procedure Info window will trigger any auto note prompts
Default Claim Note: A default note that automatically copies to the Claim Note field when a claim or preauthorization is created that includes this procedure. See Edit Claim - General Tab (213).

Notes and Times for Specific Providers: When specific providers have different completed or TP’d notes and/or time allotments, create a provider specific note.
1. Click Add Note.

2. Highlight the provider.
3. On the left, select the procedure's time pattern for this provider, if different.
4. Change the provider's default procedure note, if different.
5. Click OK to save.

Provider-specific notes can be deleted without disturbing patient data.

Add Procedure Code
In Procedure Codes (1195), at the lower left, click + New.
Adding Procedure Codes is a way to create non-CDT codes. For example, create codes for supplies you dispense (mouthwash, toothpaste), when running a promotion on a procedure, or add codes used in a foreign country. The Setup security permission is required.

If entering a series of new codes, the code last added will show under Previously Entered Code for reference.

Select the Type of the new code. Depending on the selection, some fields on the right will populate.

Complete each field listed under Edit these fields for each new code. These fields are required.

- **Procedure Code**: The new code. Up to 15 numbers, letters, or symbols are allowed. All codes starting with D will be shortened to 5 characters before being included on an insurance Claim. For example, you can have two different codes for nitrous, with the difference being a letter that is added to the end of a standard D code. When sent to insurance, only the standard 5 digit code will be used.
- **Description**: If this code starts with D and is billed to insurance, the description will show on the claim.
- **Abbreviation**

Select other procedure code options as needed. For more details, see Procedure Code Edit.

- **Do not usually bill to insurance**: Code will not be included on insurance claims.
- **Is Hygiene Procedure**: Automatically assign the procedure to the hygiene provider when scheduling an appointment with two providers.
- **Is Prosthesis**: Additional prosthesis replacement information must be entered for the procedure before sending a claim.
- **Paint Type**: Determines how the procedure will be drawn on the Graphical Tooth Chart.
- **Treatment Area**: Determines the surface and tooth options available when charting the procedure.
- **Category**: The category this procedure code will be organized under.

Click **Add, then another** to save the procedure code and keep the New Code window open.

Click **Add** to save the procedure code and close the window.

Click **Close** to close the window without saving the procedure code.

The new procedure code will appear in the Procedure Code List under its category.
Fee Override for Provider or Clinic

In the Procedure Codes (1195) list, to the right of the main grid, is the Compare Fee Schedules section.

When entering procedure fees in Fee Schedules (914), you can optionally enter fees that are provider and/or clinic specific. This can reduce the number of fee schedules you need. Provider and/or clinic specific fees are useful in the following situations:

- A PPO plan has different fee tiers depending on the provider (e.g. dentists have one fee, specialists have a different fee).
- Clinics (1505) have different fees depending on geographical location.
- A provider's fee varies depending on the clinic they provide service in.

Fee Logic: Open Dental first determines the fee schedule to use, according to the Fee Schedule Logic (1209). After that, it applies overrides in this order:

1. Clinic and provider override.
2. Provider-only override.
3. Clinic-only override.
4. Global fee.
**Enter Provider and/or Clinic Specific Fees**
Select the fee schedule criteria on the right under **Compare Fee Schedules**. These options determine which fee columns and fees show in the Procedures grid.

**Fee 1** options determine the fees that show in the Fee 1 column.

**Fee 2** options determine the fees that show in the Fee 2 column.

**Fee 3** options determine the fees that show in the Fee 3 column.

**Fee Schedule**: Click the dropdown or [...] to select the fee schedule.

**Clinic**: To enter fees specific to a clinic, click the drop down or [...] to select the clinic.

**Provider**: To enter fees specific to a provider, click the drop down or [...] to select the provider.

Note: Clinic and Provider are only enabled if the fee schedule allows provider and/or clinic-specific fees (**Use Global Fees** is unchecked).

As you select criteria, the fees in the corresponding column will change to reflect the current fee entered for the fee schedule, clinic, and/or provider. The fee color is a quick method of identifying if a fee is global or specific. A color legend shows in the lower right. Customize colors in **Definitions: Fee Colors** (868).

Click in a cell to enter the fee. Press tab to move from cell to cell for quick data entry. If you delete a fee override, the fee will revert to the global fee.

Click **Close** to save the fees and close the window.

To view all fees by procedure, double-click the procedure, then click **More** to View provider and clinic-specific fees.

**Example Scenarios**

For **PPO Plan1**, dentists Dr. Jones and Dr. Smith use the same fees, but Dr. Wilson, an endodontist, has different fees for some procedures.
1. Create one normal fee schedule (e.g. PPOPlan1) and uncheck **Use Global Fees**.
2. In the **Procedure Codes** (1195) enter the dentist fees as the global fees and provider overrides for the endodontist.
   - For Fee 1 and 2, select the PPOPlan1 fee schedule.
   - For Fee 2, select Dr. Wilson as the provider.
   - In the Procedures grid, Fee 1 column, enter the dentist fees. These will be the global fees.
   - In the Fee 2 column, enter Dr. Wilson's fees when they differ. These fees will override the global fees when Dr. Wilson is the treating provider.

Clinic A, B, and C have the same UCR fees, but Clinic D has different UCR fees.
1. Create one normal fee schedule (e.g. Standard Fees) and uncheck **Use Global Fees**.
2. In the **Procedure Code List**, enter the fees for Clinic A, B, and C as the global fees. Enter clinic overrides for Clinic D.
   - For Fee 1 and 2 select the Standard Fees fee schedule.
   - For Fee 2, select Clinic D.
   - In the Procedures grid, Fee 1 column, enter the standard fees for Clinic A, B, and C.
   - In the Fee 2 column, enter the fees for Clinic D when they differ.

Dr. Jane and Dr. George are both specialists at Clinic A and their fees differ from the UCR fees of other providers. Dr. George also works at Clinic B and his fees there are different as well.
1. Create one Normal fee schedule for Standard Fees.
2. In the **Procedure Code List**, adjust the fees:
   - For Fee 1, 2, and 3, select the Standard Fees fee schedule.
   - For Fee 1, select Dr. Jane as the Provider.
   - For Fee 2, select Clinic A and Dr. George.
   - For Fee 3, select Clinic B and Dr. George.
   - In the Procedures grid, enter the fees in the correct column.
3. Assign the Standard Fees schedule as needed. The fees will automatically adjust based on clinic and treating provider.
Dr Matt is in-network, but Dr Ashley is out of network and will not be taking any write-offs.
1. Create one Normal fee schedule and uncheck Use Global Fees.
2. In the Procedure Code list enter Dr Matt's in network rate as the global fees.
3. Using the Fees Copy (1211) tool, copy the UCR fee schedule to the new in-network fee schedule with Dr Ashley selected in the Provider option.
4. When Dr Ashley is attached to a procedure using this insurance the UCR fee will be billed and no write-off estimates will be applied.

Note: The treatment planned estimates for Dr Ashley will not be accurate. You may need to manually enter coverage for the patient portion estimate. The account will reflect accurately once the claim is paid.

Hygiene Procedures and Fees
When there are multiple providers who have different allowed hygiene procedure fees for the same in-network (PPO) insurance plan, it can affect the insurance and patient portion estimates for hygiene procedures (e.g. when one provider is premier and the other is basic PPO). Hygiene procedure fees are calculated based on the rate of the provider on the exam. If providers have different rates, the hygiene procedure's reimbursement fees will differ by exam, as can the estimated patient portion.

The best solution for this scenario is to err on the side of overcollection.
1. Create one fee schedule (e.g. PPO Plan 1). For each provider that might be on a hygiene exam, enter the highest allowed fee among the providers for each hygiene procedure.
2. Assign the fee schedule to the patient's insurance plan.
3. When charting and completing procedures, the higher fee will always be used to calculate both insurance estimates and patient portion. This is good business practice. The fee the patient will expect and be prepared for will be the higher fee. If the insurance payment ends up being lower (because the lower paid provider did the exam) you can then issue a refund.

Note: In this scenario, we do not recommend paying hygienists based on net production, as their compensation will vary depending on the provider on the exam. There is no current way in Open Dental to have an accurate picture of the hygienist's income. For providers that are paid on collection, base the rate on actual income, not production, because production values will be inflated.

For each hygienist, enter the highest fee for each hygiene procedure. Leave blank for non-hygienic procedures.

Example: For PPO Plan 1, prophy procedure: Dr. A has a fee of $200. Dr. B has a fee of $100. Insurance pays 80% ($160 for Dr. A, $80 for Dr. B). Patient portion for Dr. A is $40, for Dr. B is $20.

Steps:
1. When entering hygiene procedure fees for each provider that might be on a hygiene exam, use Dr. A's fees (the highest).
2. Assign the fee schedule to the patient's insurance plan.

When the hygienist does a procedure on Dr. A or Dr. B’s exam:
- The fee will be $200.
- The estimated patient portion will be $40.
- The estimated insurance payment will be $160.

When the insurance payment comes:
- When Dr. A is the provider on the appointment, insurance will reimburse $160, and the write-off and payment portion will be accurate.
- When Dr. B is the provider on the appointment, insurance will reimburse only $80. The patient will have overpaid their portion ($20), so reimburse as needed.
ADA CDT Codes

The ADA license allows us to include the ADA (CDT) Procedure Codes for distribution within the United States only. As required by the ADA CDT content license, every U.S. customer of Open Dental Software must fill out and return a CDT Compliance Form. This form discloses in writing the number and location of all end-user sites that use the software, and thus the CDT codes.

To download new CDT codes, see Procedure Code Tools.

What locations are considered United States?

The ADA license specifically addresses this as follows: The U.S. version of Open Dental may be distributed in all 50 states, the District of Columbia, the Commonwealths of Puerto Rico, and the Northern Mariana Islands or any territory of the United States.

Based on this wording, the following locations are considered within the U.S. for licensing purposes:

- 50 States
- Washington DC
- Puerto Rico
- Northern Mariana Islands
- Guam
- US Virgin Islands
- American Samoa

Countries not included in this list must arrange their own purchase of CDT codes and ADA claim forms.

Fee Schedule Logic

See Procedure Codes.

The Fee Schedule used for procedure fee estimates is determined using the logic below.

Insurance

If the patient has insurance, the fee schedule of the first insurance plan listed in the Family module is used (e.g. order = 1 on the Insurance Plan).

If the insurance is a PPO plan that has two fee schedules (PPO fee schedule and Provider fee schedule), the procedure fee is based on the fee schedule that has the higher fee.

No Insurance

(rare) If there is no insurance and a fee schedule is set for the patient in the Edit Patient Information, this fee schedule is used.

Otherwise, for patients without insurance, the fee schedule of the provider who has priority is used.

- Priority 1: The provider assigned to the procedure, if any (Assign to Prov on the Procedure Code).
- Priority 2: The provider assigned to the procedure's appointment or to any appointment scheduled today.
- Priority 3: The patient's primary provider.

Medical

If the patient has medical insurance, the fee schedule of the first medical insurance plan listed in the Family module is used.
If a Procedure Code (1200) is a dental code cross-coded to a medical code, then the setting in Chart Module Preferences (706) for Use medical fee for new procedures determines the fee. If checked, the fee of the medical code is used; if unchecked the fee of the dental code is used.

**Overrides**

After the fee schedule is determined, then any Provider and/or Clinic-Specific Overrides (1206) are applied to that fee schedule.

**Fee Tools**

In Procedure Codes (1195), in the lower right click Fee Tools.

Choose Settings: Select the criteria for fees that will be copied, exported, imported into, increased, or cleared.

Copy To: Select where fees will be copied to. See Fees Copy (1211).

Export: Export fees that meet Choose Settings criteria to a txt file. See Fees Export (1216).

Import: Import fees from a tab delimited file into the Choose Settings fee schedule. See Fees Import (1214).

Clear: Erase all fees in the Choose Settings fee schedule. A confirmation message will show.
**Increase by %**: Incrementally increase by a percentage all fees that meet Choose Settings criteria. See [Fees Increase](1212).

**Global Update Fees**: Apply fee changes from all fee schedules to all treatment planned procedures at once (active and inactive treatment plans only). See [Fees Update](1218).

- Clinic: Use the dropdown menu to select the clinic you would like to update fees for. Use the ctrl key to select more than one. Procedures in treatment plan must have a clinic associated for clinic selection to update the fee.
- Only the fee will be updated, not insurance estimates.
- Fees in saved treatment plans are not affected.

**Global Update Write-off Estimates**: Update the write-off estimates for all treatment planned procedures.
- If using clinics, this tool will update write-off estimates for all clinics.
- This tool may take a while to run. A progress bar will show. You can pause or cancel the process at any time.

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**Fees Copy**

In [Fee Tools](1210), at the left, is the *Copy To* section.
Use to copy fees in one fee schedule to a different fee schedule. Only fees that exactly match the selected criteria will be copied. You can copy only global fees in a fee schedule or further narrow your criteria to only clinic and/or provider-specific fees. As a preventive measure, before changing fees in a fee schedule (e.g. Fees Increase(1212) or Fees Import(1214)), we recommend creating a backup copy of the original fees.

Note: In some older versions, copying a fee schedule to itself will blank out the fee schedule. To avoid this issue, update your Open Dental version to 16.2.74 or greater, 16.3.40 or greater, or 16.4.9 or greater.

If needed, create a new Fee Schedule(914) to use as the backup copy (e.g. 2014fees).
- In the Main Menu(592), click Lists, Procedure Codes.
- Click Fee Scheds (bottom right).
- Click Add and create the fee schedule.
- Click OK, then Close.

Click Fee Tools.

Under Choose Settings, select the fee criteria to copy by clicking the dropdown arrows or [...] . Clinic and Provider options are only enabled if the selected fee schedule allows clinic and provider-specific fees (Use Global Fees is unchecked). Only fees that exactly match the criteria will copy:
- If you select only a fee schedule, only the global fees will copy.
- If you select a fee schedule and a clinic, only the clinic-specific fees will copy.
- If you select a fee schedule and a provider, only the provider-specific fees will copy.
- If you select a fee schedule, a clinic, and a provider, only fees that are clinic AND provider specific will copy.

Under Copy To, select where the fees will be copied to. We recommend selecting similar criteria as the Choose Settings criteria. To select multiple clinics, use the clinic picker [...].

Click Copy. A warning message will show.

Click OK to continue.

A message will indicate when the copy is done. Click OK.

Fees Increase
In Fee Tools(1210), at the right, is the Increase by % area.
Use this tool to incrementally increase or decrease fees in a fee schedule by a percentage. We recommend first creating a backup copy of the original fee schedule, then updating the original fee schedule with the new fees.

Step 1: Make a backup copy of the fee schedule. See Fees Copy (1211). This is a preventative measure.

Step 2: Increase or decrease the fees in the original fee schedule.

Under Choose Settings, select the fee schedule to increase/decrease by clicking the dropdown arrows or [...]. Clinic and Provider options are only enabled if the selected fee schedule allows clinic and provider-specific fees (Use Global Fees is unchecked).

Only fees that exactly match the criteria will copy:
- If you select only a fee schedule, only the global fees will change.
- If you select a fee schedule and a clinic, only the clinic-specific fees will change.
- If you select a fee schedule and a provider, only the provider-specific fees will change.
- If you select a fee schedule, a clinic, and a provider, only fees that are clinic AND provider specific will change.

In the Increase by % field, enter the percentage of the increase (e.g. 5). To decrease fee amounts, enter a negative value.

Select the rounding method. We recommend rounding to the nearest $1.

Click Increase. A message will show warning that all fees that meet the Choose Settings criteria will be overwritten.
Click OK to apply the fee change.

If the change worked as desired, hide any old fee schedules (with the old fees).

- On the Procedure Codes window, click Fee Scheds.
- Double click the old fee schedule and mark it hidden. It will no longer show as a selection in various lists.

Note: If you choose to add new fee schedules (instead of making a backup and increasing fees in the original), you may also need to update fee schedule selections for insurance plans and providers.

To apply updated fees to treatment planned procedures, see Fees Update(1218).

Fees Import

In Fee Tools(1210), at the lower left, is an Import button.
Fees can be imported into fee schedules (e.g. if insurance sends a new fee schedule). For the fee to import, the corresponding code must already exist in the **Procedure Codes**.

**Note:** Importing codes and fees will not automatically add a code.

Usually it is easiest to manually enter or edit fees in a fee schedule instead of importing it (create the fee schedule, nine-key in the fees). Often the fee schedules provided to offices have no standard format. Thus, taking a PDF, printed fee schedule, or custom formatted fee list and editing it for import can be difficult. Large offices may have IT staff handle fee schedules import, but in general, importing fees is a technical process and advanced feature.

**File Format Requirements:** Fees must be saved as a tab delimited file (txt file is preferred). To see an example of the correct file format, export the fees ([Fees Export](1216)). When opened with Notepad, it will look similar to this:
The first column of the imported file must contain the procedure code; the second column must contain the fee with no monetary symbols or extra characters/spaces.

The columns must be separated by tab.

Abbreviations and descriptions are ignored during import.

Fee sort order does not matter.

Close the file before importing the fees.

**Hint:** To only make changes to a few fees, create a tab delimited .txt file that only contains those codes and fees, then import it. Only those codes will be updated.

**Step 1:** Make a backup copy of the fee schedule. See Fees Copy(1211). This is a preventive measure.

**Step 2:** Import the fees into the original fee schedule:

Under Choose Settings, select where the new fees will be imported into. You can import into only a fee schedule (global fees), or further narrow to clinic and/or provider specific fees.

To erase any existing fees in the Choose Settings fee schedule, click Clear.

Click Import. You will receive a warning message.

Click OK to continue and import the fees.

To apply updated fees to treatment planned procedures, see Fees Update(1218).

**Fees Export**

In Fee Tools(1210), at the bottom left, is an Export button.
Exporting fees is useful when you want to make minor changes to an existing fee schedule. First export saved fees as a txt file in the correct file format. Procedure code, fee, abbreviation, and description are exported. Then change fees as needed and import fees (see Fees Import(1214)).

Under Choose Settings, select the fee criteria to export by clicking the dropdown arrows or [...] You can export only a global fees (fee schedule), or further narrow the export to clinic and/or provider-specific fees.

Click Export.

Select the location and file name, then click Save. By default it is saved as a txt file in the OpenDentalExports folder.

Note: To export a fee schedule as an excel file (.xls), use the Procedure Codes - Fee Schedules Report(1361) instead.
To change fees, open the saved file, make the changes, then save the file. If making changes that will be imported back into Open Dental, only code and fee changes will be recognized.

Exported fee schedule example

Another option to export fees is to run the Procedure Code Report (1361) by code, then export the results.

Fees Update

In Fee Tools (1210), at the lower right, is the Global Update Fees area.

When you change fees in a fee schedule, new procedures will reflect the new fees. However, procedures in active or inactive treatment plans are not automatically updated. There are two update fee options: update fees for all treatment planned procedures at once or update fees one treatment plan at a time. Instructions for both options are explained below.

- **Note:** These tools can only be run using a direct connection to the database (not a Middle Tier connection). If you are not using a direct connection they will be grayed out and unavailable.
- Estimates are automatically updated when creating a claim.
- Fees in saved treatment plans are not affected when updating fees.

**Update Fees for all Treatment Planned Procedures**

This method will update all procedure fees at once. It will not affect insurance estimates. Updated fees in all fee schedules will be applied.

If using Clinics, highlight the clinic(s) to update fees for. To select multiple clinics, click and drag or press Ctrl while clicking.

Click Update. A confirmation message will show.
Click OK to proceed.

When complete, a message will indicate the number of procedure fees that were changed. Click OK to close the message.

**Update Fees for One Treatment Plan**

This method is useful when you plan to honor old fees for a certain grace period. It will update all treatment planned fees and insurance estimates for the selected patient only.

Select the patient.

In the **Treatment Plan Module** (283), select the treatment plan.

Click Update Fees in the toolbar.

A confirmation message will show.
New Year

In Open Dental, there are no close out tasks required at the end of the year. However, there are some setup tasks you may want to consider as you begin the new year.

Blog Post: Your 7-Step New Year Checklist

Procedures:
- Use Fee Tools (1210) to adjust procedure fees (increase by a percentage, import new fees).
- Update procedure codes (e.g. CDT codes). Procedure Code Tools (1198)

Scheduling and Time Clock:
- Add days to the schedule. Schedule Setup (1099)
- Set up pay periods (if using the Time Card). Time Card Setup (773)

EHR providers:
- Sign a new EHR contract for the current calendar year. Contact Open Dental support.
- Meaningful Use: Configure and setup items for EHR Modified Stage 2 as needed.

FAQ

Below are common questions asked by Open Dental users at the beginning of each new year with answers that can be found in the user manual. For another resource see Start of a New Year (1220).

How do I update ADA procedure codes for the new year?

New codes are usually included in the last stable release of the year. Update to the version as needed, then run Procedure Code Tools to update. See Procedure Code Tools (1198).

How do I update fees? There are a few methods:
- Increase fees in an existing fee schedule by a percentage. See Fees Increase (1212).
- Import a new fee schedule into an existing fee schedule. Only tab delimited files can be imported (.txt file is preferred). See Fees Import (1214).
- Create the new fee schedule, then reassign it to multiple insurance plans. See Check Ins Plan Fees (916).
- Manually enter new fees in an existing fee schedule. See Procedure Codes (1195).
- Canada: New fee guides are released as we receive them. See Canada Fee Guides to download them into Open Dental.
Do I need to manually reset patient insurance benefits for the new year?
No, patient insurance benefits will automatically reset on January 1st or the first day of the month indicated in the service year.

How do I clear out adjustments to insurance benefits?
Adjustments are cleared out automatically when the new benefit year begins, so you don't need to do anything.

I have a plan that is no longer in-network. How do I change the insurance plan for all patients on the plan?
First create the new plan, setting the correct plan type. Then use the Move Subscribers tool to move subscribers of the existing plan to the new plan. See Move Subscribers(1411).

I have a plan that has a new fee schedule? How do I change it for all patients on the plan?
Go to the Insurance Plans(1244) and change the fee schedule for the plan.

My employees are not able to clock in using the time clock. What do I need to do?
You probably don't have pay periods set up for the new year. See Time Card Setup(773).

My appointment book doesn't show any open times. What do I need to do?
You probably need to add days to the schedule for the new year. See Schedule Setup(1099).

What year end reports do I need to run?
Many users find these reports useful.
- Production and Income Reports
- Daily Procedures Report
- Accounting reports (General Ledger Details or Balance Sheet)
- Aging of Accounts Receivable Report

If you had a conversion during the year, reports should be run out of your old software through the date of conversion (e.g. January through date of conversion), and out of Open Dental from the day after conversion and forward (day after conversion through Dec. 31).

What do I need to do to close out the month?
There is nothing that you officially have to do to close out a month in Open Dental. All your financials roll over and when the calendar changes, so does Open Dental. For tasks that aren't required, but that you may find useful at month's end, see Close Out Month(1284).

What do I need to do to close out the year?
There is nothing that you officially have to do to close out the year in Open Dental. However, there are some security features to prevent changing data after a certain date, such as locking accounting entries and setting global lock dates. See Security Lock Dates(1122).

I am going to participate in the EHR Incentive Program in the new year. What steps do I need to take?
Contact us to sign a new Open Dental EHR contract for the new calendar year. See Open Dental EHR to download the purchase form. Refer to EHR Modified Stage 2 for meaningful use requirements.

Allergy List
The master allergy list contains the allergies that can be added to a patient’s allergy list.

In the MainMenu(592), click Lists, Allergies.
Alternatively, you can access Allergy Setup by going to Setup, Chart, EHR (EHR Setup Window(709)), Allergies(472)

Allergies are listed alphabetically. To show allergies marked hidden, check the **Show Hidden** box.

Click **Add**, or double click an allergy to edit.

Allergies can also be added to the master list while editing a **Medical History Sheet**(1165).

**Description**: Enter the allergy name.

Only used in EHR for CCDS: Most non-EHR offices can ignore these.

**Allergy Type**: A value is required in order for the allergy to list on an **EHR Continuity of Care Document (CCD)** (414) (e.g. Summary of Care).

**Allergen**: Only one value (UNII or Medication) can be entered, not both.
- **UNII**: Used for ingredient allergies (e.g. latex, peanuts). Enter a UNII to show this allergy on the CCD. Must be manually
entered as a 10 character, uppercase, alphanumeric code. To search for UNII codes see http://fdasis.nlm.nih.gov/srs/srs.jsp.

- **Medication**: Click [...] to select from the Medications List (1246). To show on a CCD, medication allergies must be associated with medications that have an RxNorm. Click None to clear the box.

Click OK to save.

**Is Hidden**: Check the box to hide the allergy so it can't be selected for other patients. It will continue to show for patients already using it.

**Delete**: Remove an allergy. Allergies in a patient's allergy list cannot be deleted.

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**Clinic List**

In the **Main Menu** (592), click Lists, Clinics.

All **Clinics** (1505) that are currently set up show in the Clinics list. From here you can enter contact information, specialties, payment and billing addresses, and default providers. You can also reorder the list of clinics, or move patients from one clinic to another.

**Show Hidden**: Check/uncheck to display/hide hidden clinics in the Clinics list.

**Pat Count**: Number of patients assigned to a clinic. Counts patients who have a status of **patient**, **inactive**, or **prospective**.

Note: When patients or employees do not have a clinic assignment, they will default to the Headquarters clinic.
Add or Edit a Clinic

1. On the Clinics window, click Add or double click an existing clinic to open the Clinic (1224).
2. Enter the clinic information.
3. Click OK to save.

Reorder Clinics

The order of clinics in the Clinics list affects the order in other dropdowns throughout the program. By default clinics are sorted in the order they are created.

**Order Alphabetical**: Check this box to automatically sort the clinics in alphabetical order. This will also disable the up/down buttons. Any new clinics will also be automatically sorted alphabetically.

To manually reorder clinics:
1. Uncheck Order Alphabetical.
2. Highlight a clinic.
3. Click the Up/Down arrows to move it up or down in the list.

Hide a Clinic

Hiding a clinic removes it as a selection option in various dropdowns throughout Open Dental.
1. On the Clinics window, double click the clinic.
2. Check Is Hidden.
3. Click OK to save.

Note: When a user only has access to a single clinic, that clinic cannot be hidden until the user restriction is removed. See User Edit (1109).

Move Patients to another Clinic

Use the Move Patients tool to reassign patients to another clinic.

1. Highlight the clinic you want to remove patients from.
2. In the Move Patients area, click [...], then select the clinic to move the patients to.
3. Click Move. A confirmation message will show.
4. Click OK to move the patients.
5. A message will indicate when the move is complete. Click Done to close.

Clinic

In Clinics (1223), click Add, or double-click an existing clinic to edit.
Use the Edit Clinic window to enter basic contact and preference information for Clinics (1505).

**Basic Details**

**Is Medical**: Mark the clinic as a non-dental clinic. When this clinic is selected in the main menu, a non-dental interface will show. See Non-Dental (932).

**Clinic ID**: A system generated unique identifier that is useful for third party reporting.

**External ID**: A customizable identifier that can be used for mapping purposes.

**Abbreviation**: A clinic identifying abbreviation that will show in dropdowns and pick lists throughout Open Dental. It can also optionally show in the Open Dental title bar instead of the Description. See Miscellaneous Setup (921).

**Description**: The clinic name. It will show on statements, letters, etc.
Phone, Fax: The clinic phone and fax number.

Region: The clinic's region. Customize options in Definitions: Regions(889).

Hide from Insurance Verification List: Determines if this clinic's appointments will show in the Insurance Verification List (49).
- Checked: Include this clinic's appointments in the list.
- Unchecked: Exclude this clinic's appointments from the list

Proc code required on Rx from this clinic: Requires procedure codes to show on printed prescriptions. This option is only available if Procedure code required on some prescriptions is checked for the prescription in the Rx / Prescriptions List(1264).
- Checked: Requires printed prescriptions to include a procedure code.
- Unchecked: Do not require a printed prescription to include a procedure code.

Proc code required on Rx from this clinic: Determines if this clinic is required to add a procedure code to prescriptions. See Rx / Prescription(333) for all setup steps. Useful for clinics in states that require a procedure code on prescriptions (e.g. Ohio).

Address Tabs

Physical Treating Address: The address of the clinic's physical location (where treatment is performed). This address shows on the clinic's statements.

Billing Address: The clinic's billing address. Also check Use on Claims to use this address on e-claims and printed claims. It cannot be a PO Box.

Pay To Address: The address where insurance payments for this clinic should be sent. It can be a PO box.
- In 5010 e-claims it is sent with the billing address.
- On printed claims it overrides the billing address.

Note: For the logic that determines what addresses are sent on printed and e-claims, see Claim Addresses(223).

Specialty: Assign one or more clinic specialties. Customize options in Definitions: Clinic Specialties(862). Clinic specialties are useful to differentiate Clinic(145).
- Click Add, then double click a specialty to add.
- Select a specialty, then click Remove to remove it.

Other Details

Email Address: Click [...] to select the clinic's Email Address(747). Click None to clear the field.

Bank Account Number: The default bank account number to use for this clinic's Deposit Slip(516).

Default Insurance Billing Provider: Set the default provider for claims.
- Default Practice Provider: The default provider set in Practice Setup(931).
- Treating Provider: The treating provider. See Claim(208), Treating Provider for logic that determines who the treating dentist is.
- Specific Provider: A specific provider. Then click the dropdown or [...] to select the provider. Click None to clear the field.

Default Provider: Select the default primary provider when a new patient is created for this clinic.

Default Proc Place of Service: The default place of service assigned to procedures for this clinic (Procedure - Misc Tab(315)). Usually for Public Health(71). This will give you accurate public health reports about the exact clinic and place of service where each procedure is performed (useful for mobile vans or nursing homes). If using mobile vans, you can also use Sites(1272) to track schools or community locations where a service is performed.
**Scheduling Note:** Text entered here will display when the user clicks on an operatory header in the appointment schedule and this clinic is selected.

**Is Hidden:** Mark a clinic as hidden. This removes the clinic as a selection option in various areas of Open Dental.

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**Contacts**

In the [Main Menu](#) (592), click Lists, Contacts.

Alternatively, press **Ctrl+Shift+C**.

The Contacts lists is a reference list of phone and fax numbers you commonly use.

To add, edit or rearrange categories, see [Definitions: Contact Categories](#) (865).
Click Add, or double-click an existing contact to edit.

Counts

In the Menu (592), click Lists, Counties.
Counties are used in Public Health(71).

Click Add.
**County Name**: Enter the name of the county. This name will appear in a dropdown when matching text is entered in the County field on the Edit Patient Information (62). If you later change a county name, it changes it for all patients using it.

**County Code**: (optional) Enter additional information about the county.

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**Discount Plans**

The Discount Plan feature is useful for practices that offer in-house discount plans for patients that do not have insurance.

In the Main Menu (592), click Lists, Discount Plans.

This feature uses discount adjustments to reduce the full procedure fee. The adjustment amount is calculated by subtracting the discount plan's procedure fee from the provider's UCR fee.

- **Description**: The name of the discount plan.
- **Fee Schedule**: The fee schedule assigned to the discount plan.
• **Adjustment Type**: The adjustment type selected for the discount plan.
• **Pats**: lists the number of patients currently using this discount plan.
• **Hidden**: An X will display for discount plans marked *Hidden*.
• **Show Hidden**: Check to include Hidden plans in the list.
• **Add**: Create a new discount plan (see below).
• **Merge**: Combine two discount plans. See: [Merge Discount Plans](1405)

### There are three main steps to create a Discount Plan

1. Create the adjustment type that will be used for the discount plan's adjustments:

   This adjustment type will be associated with all adjustments for the discount plan. Also see [Definitions: Adj Types](841).
   In the [Main Menu](592), click Setup, Definitions, Adj Types. Click Add. Name the new adjustment type, enter `dp` to flag it as a discount plan adjustment, then click OK.

   ![Edit Definition](image)

   Note: If you have multiple discount plans, consider creating an adjustment type for each plan to track adjustment totals.

2. Create the discount plan's fee schedule and enter its fees:

   There are two options. Also see [Procedure Codes](1195).
   - Enter the fees manually.
   - Copy the UCR fee schedule, then decrease fees by a percentage.

3. Create the discount plan (associate the adjustment type and fee schedule):

   In the Discount Plan list above, click **Add**, or double-click to edit.

   ![Discount Plan Edit](image)

   Enter the name of the discount plan in **Description**. Click [...] to select the discount plan's **Fee Schedule**.

   Select an **Adjustment Type** from the dropdown to use for the discount plan. Only adjustment types flagged as `dp` are options. The number of **Patients** currently using this discount plan will display. Click the dropdown to view the list of names. Note: The **Insurance Plan Edit** security permission is required to add or change discount plans.
**Remove/Hide Discount Plans**
Hidden discount plans will not show in the Discount Plan list unless *Show Hidden* is selected. Only discount plans not associated to patients can be hidden.

1. In the Main Menu, click Lists, Discount Plans.
2. Double click the discount plan to hide.
3. Check the Hidden box.
4. Click OK to save.

Run the *Discount Plans Report* (1354) to view a list of all or a specific discount plan, the associated fee schedule, adjustment type, and patients using the plan.

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**Dental School Classes**
In the *Main Menu* (592), click Lists, Dental School Classes.

For Dental Schools (808), classes refer to student groupings (e.g. Hygiene class of 2014). Every student provider must be associated with a class, so classes must be created before adding students.

Click **Add** or double click a class to edit.

**Graduation Year**: Enter the class graduation year.

**Description**: Enter a description (dental or hygiene).
Click OK.

**Delete**: Click to delete the class. Classes can only be deleted if there are no students attached to them.

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### Dental School Courses

In the **Main Menu** (592), click Lists, Dental School Courses.

For **Dental Schools** (808), courses must be defined before **Dental Student Evaluations** (1439) can be created.

Courses are sorted alphabetically first, then numerically by ID number.

Click **Add** or double click a course to edit.

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**Course ID**: Enter the identification code for the course.

**Description**: Enter a description.

**Delete**: Click to delete the course.

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### Employees

In the **Main Menu** (592), click Lists, Employees.
The Employee list is used to set up User Edit (1109) and to set up schedules (Schedule Setup (1099)). This list also determines who can use the Time Clock (582).

Click Add, or double-click an employee to edit.

Payroll ID is only used if processing payroll through a third party (such as ADP).

Click OK to save.
Inactive employee: If an employee no longer works at the practice, check the Hidden box. The employee will no longer be a selection in other lists.

**Advanced Tools**

**Delete all unused employees**: This is fairly safe to use. Employees that have time clock events attached to them will not be deleted.

For steps to take when an employee leaves the practice, see **Employee Leaving** (1235).

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**Employee Leaving**

If an employee leaves your practice, here are some steps you can follow.

Note: If using the **Time Clock** (582), do not hide or delete any employees until payroll has been processed.

1. **Task List and Inbox** (1705): Employee task lists can be renamed or reassigned to a new user. To remove it as a To Task List option, right click on the list, click Edit Properties, then set the Object Type as None.
2. **Schedule Setup** (1099): Remove the employee from the daily schedule. Use the Copy Day/Copy Week feature to change future days as needed.
3. **Employees** (1233): Mark the employee as hidden.
4. **Security** (1106): Mark the user as hidden. Users cannot be hidden if they have the Security Admin permission.

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**Provider Leaving**

If a **Provider** (1255) (doctor or hygienist) is leaving, there are additional steps to follow.

1. **Operatories** (628): If the provider is assigned to an operatory, change the provider, or select none.
2. **Move Patients**: Move the provider's patients to a different provider.
3. **Provider Edit** (1255): Mark the provider as hidden. This will remove the provider as a selection option for appointments and procedures, and it will delete any future schedule for the provider.
4. Manually remove the provider from future appointments (you will need to select a different provider) or use the **Update Provs on Future Appts** (54) to reassign all appointments for a specific operatory to the scheduled provider.

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**Employers**

In the **Main Menu** (592), click Lists, Employers.
The Employer master list includes all employers who have been entered for a patient on the Edit Patient Information (62) or Insurance Plan (81). This list is automatically updated whenever you enter a new employer name.

Click Add, or double-click an employer to edit.

Enter the employer name.

Click OK to save.

**Combine Employers**
If you accidentally end up with multiple variations of a single employer with different spellings, you can combine them into a single record.

1. Highlight the employers to combine.
2. Click Combine.

3. Click OK to proceed.

All combined employers will merge into the employer selected at top. All patient and insurance records will be updated.

**Delete an Employer**

You can not delete employers that are in use.

1. Highlight the employer.
2. Click Delete.
3. A confirmation message will show. Click OK to proceed.

**Carriers**

In the Main Menu (592), click Lists, Insurance Carriers.

You can also access the carrier list by clicking [...] on the Insurance Plan (81) window.

Carriers are automatically added to the master list when you enter carrier information on an insurance plan, but you can also add carriers that are not attached to any plan.

The number of plans a carrier is attached to is indicated in the Plans column. To narrow or sort the list of carriers, enter filter criteria:

- **Carrier/Phone**: As you type, only matching entries will list.
- **Show Hidden**: Include/exclude carriers that have been marked Hidden.
• **CDAnet Only**: Show only CDAnet carriers in the list. (Canadian Dental Association)

To update carrier information, double-click it.

If multiple entries for the same carrier exist due to data entry errors, you can combine them. See [Combine Carriers](#).

## Add a Carrier

| Carrier ID | 14 |
| Carrier Name | Employee Insurance |
| Phone | (503)555-5555 |
| Address | 123 Street Ct |
| Address2 |  |
| City, ST, Zip | Salem, OR 97301 |
| Electronic ID | 1234 |

- **Send Electronically**: Determines the carrier's default setting for Send Electronically on the Insurance Plan.
  - Send Claims Electronically: Allow sending E-Claims to this carrier.
  - Don't Send Claims Electronically: Do not allow sending e-claims to this carrier (e.g. if you must print and mail).
  - Don't Send Secondary Claims Electronically: Do not allow sending secondary e-claims to this carrier (e.g. when carrier requires that secondary claims are mailed with a copy of the primary EOB).
**Carrier Group:** Only visible if carrier group names exist in Definitions: Carrier Group Names(854). Select a carrier group to associate to the carrier. Useful for queries.

**Hidden:** Hide this carrier so it is no longer available as a selection.

**Is trusted for real-time eligibility:** Check to enable to automated import of Electronic Eligibility and Benefits(108) when using Scheduled Processes(810) for this carrier.

**Appt Text Back Color:** Background color for the carrier’s name in the appointment box when Insurance Color is added to the appointment view. See Appointment View Edit(622).

**Import Benefit Coinsurance:** When importing benefits using Electronic Eligibility, select how Open Dental imports received carrier benefit information. This affects insurance estimates.
- Carrier sends patient % (default): The carrier will send the percentage covered by the patient. Open Dental will import this as the percentage covered by insurance. For example, if patient pays 20%, Open Dental will import this as Insurance Pays 80%.
- Carrier sends insurance %: The carrier will send the percentage covered by insurance. Open Dental imports these benefits as they are.

**Ins Plan Subscribers:** Indicates how many insurance plan subscribers use this carrier. Click the dropdown to see all subscribers.

**Delete:** You can not delete a carrier that is in use, but you can combine carriers.

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**Canada Carriers**

For Canada users, click Lists, Insurance Carriers(1237).
Carriers are automatically populated and easily maintained. Insurance carriers marked as CDANet are capable of sending electronic claims to ITRANS or Claimstream (TELUS).

Search criteria:
- **Carrier**: Search the list by carrier name.
- **Phone**: Search the list by carrier phone number.
- **Show Hidden**: Check to include carriers marked as hidden.
- **CDAnet Only**: Check to only show carriers marked as CDANet.

Click **Refresh** to update the list.

To update your Carriers list, select your criteria and click **Update Carriers**. This button is for ITRANS 2.0 and Claimstream users only.

- **Name**: Update carrier names.
- **Address**: Update carrier addresses.
- **Phone**: Update carrier phone numbers.
- **Add Missing**: Add any missing CDANet carriers.

Note: To only update CDANet information (e.g. transaction type, carrier network, version, etc), keep all boxes unchecked and click **Update Carriers**.

Click **Add** to add a new carrier. All CDANet carriers are imported with the carrier update and should not be added manually.

Click **Combine** to merge duplicate carriers. Also see **Combine Carriers**.

Double-click on a carrier to view carrier information and CDANet information.
The Carrier information in the top half is editable by the office.

The data under CDAnet is maintained by the CDA. This information is updated when running the Update Carriers tool as noted above.

The following carriers are supported by ITRANS: [http://www.goitrans.com/itrans-support-carrier-listing/](http://www.goitrans.com/itrans-support-carrier-listing/)


Note: October 8, 2019 Note for our Canadian Customers:

We are aware of issues regarding the ClaimSecure carrier. You may receive an "Input string was not in a correct format" error when sending claims.

Claims are going through to ClaimSecure, however you are not able to view EOB or Acknowledgment responses. You may send predeterminations prior to sending the claim to view payment information.
To send a predetermination, please contact Open Dental who will assist in updating the ClaimSecure carrier. We will be reaching out to customers who have contacted us with this issue.

Combine Carriers

In the Carriers (1237) window, on the right side, is a Combine button.

Combining insurance carriers in the Carriers List blends multiple insurance carriers into one. It is useful when multiple versions of the same carrier have been inadvertently created. This can happen when you update carrier information on the Edit Insurance Plan window instead of from the master list.

Caution: Combining carriers is irreversible. When you combine carriers, only one carrier's information will be retained. Any insurance plans with the other carriers are automatically assigned the new carrier.

Select the carriers you want to combine (press Ctrl or SHIFT while clicking).

Click Combine.

Click OK to proceed.
Highlight the one carrier that the others will be combined into (the carrier to keep).

Click OK. If the carrier details differ, another warning message will show.

Click Yes to proceed. Only the kept carrier will remain in the Carriers list.
Insurance Plans

In the Main Menu (592), click Lists, Insurance Plans.

Alternatively: from the Insurance Plan (81) Edit Window, click Pick From List.

See also:
- Add Insurance (112)
- Change Insurance Plan Information (124)
- Drop Insurance Plan (126)

QuickTip video: Reordering Patient Insurance Plans

The first 200 results that match filter criteria will display. Click Get All to show all plans that match. Each line entry refers to an individual plan. The number of plan subscribers is indicated under the Subs column. Double click a plan to view carrier, plan, and benefit information.

To narrow or sort the list of plans, enter filter criteria:
- Employer/Phone/GroupName/Group Num: As you type in a field, only matching entries will list.
- Trojan ID: Only visible if the Trojan Bridge (1072) is enabled. Filter by Trojan ID number.
Plan Num: Filter by the insurance plan ID number (visible on the Edit Insurance Plan window).
Show Hidden: Include/exclude plans that have been marked Hidden on the Edit Insurance Plan window
Order By: Select the sort order of the list.

Combine: Combine duplicate plans into a single plan. See Combine Insurance Plans(126).
Hide Unused: Mark plans that have 0 subscribers as hidden.
Blank Plan: Only visible when the list is accessed via the Edit Insurance Plan window. Click to open a blank Edit Insurance Plan window.

Questions and Answers
I have duplicate insurance plans in the list. Why and how do I fix this?
There are a few reasons you may have duplicate plans. Sometimes plans look the same, but when the details are examined they are different. Thus what looks like duplicate entries is really different plans that share the same employer, carrier, group name, group number. Things to check:
- Benefits (percentages, annual max, other benefits, benefit year)
- Fee schedule assignments
- Plan type

If you created new insurance plans by mistake instead of using an existing plan, you can combine insurance plans. Combining is irreversible and changes historical data.

To avoid creating new plans inadvertently, follow these guidelines:
- When changing a plan for all subscribers via the Edit Insurance Plan window, make sure Change plan for all subscribers is selected.
- When entering a plan for a new patient, search for matching plans before creating a new plan (Pick from List).

Lab Cases
In the Main Menu(592), click Lists, Lab Cases.

Alternatively: in the Appointments Module(1), under the calendar, click Lab Cases.

The status of lab cases for the selected date shows next to the Lab Cases button. If the status is All Received, then all lab cases attached to today’s appointments have been marked Received on the Lab Case(379) Edit window. If the status is Not Received, then lab cases for today’s appointments are still outstanding. The number indicates how many lab cases
are not marked Received. If using Clinics, the status reflects lab cases attached to all appointments scheduled in the selected clinic's operators, for the selected date.

**View Lab Cases**
By default, only incomplete lab cases attached to incomplete appointments are listed. If you change a filter value, click Refresh to update the list.
- **From/To Date**: View lab cases between a specific date range.
- **Show Unattached**: View lab cases not attached to an appointment.
- **Show Completed**: View completed lab cases. Lab cases are marked complete when the attached appointment is set complete.
- **Clinic**: Sort the lab case results by selected clinic. Only visible when Clinics (1505) is enabled. The list will only include clinics the user has permission to access.

Double-click a Lab Case to change the status, usually by clicking one of the "Now" buttons in that window:
- Unsent
- Sent
- Received
- Quality Checked

To quickly jump to the associated appointment in the schedule, right click on the lab case then select Go To Appointment.

**Medications List**
The Medications master list contains all medications (generic and brand name) that can be added to a patient's chart.

In the **Main Menu** (592), click Lists, Medications.

Alternatively, in the **Medical** (466) window, Medications tab, click Add Medication.

**All Medications Tab**
This tab lists all medications that have been entered, both generic and brand name.

**Add Generic**: Add a generic medication. Generic medications must be added before associated brand names can be entered.
**Add Brand**: Add a brand name medication. You must first select the associated generic medication.

**Search**: Filter the list of medications by drug name. As you enter characters matching results will show.

**Import**: Import a list of medications that was exported from Open Dental. Alternatively, a tab delimited txt file can be imported if using the following format. No header row, four columns: Drug Name, Generic Name, Blank Column, RxNorm Number.

**Export**: Export the medications list to a txt file.

**All Medications grid**: Medications are sorted alphabetically by default. To change the sort order, click on a column header.
- **In Use**: Indicates medications that are currently prescribed to a patient or used as an EHR indicator in Chart Module Preferences (706).
- **RxNorm**: Lists RxNorms (735) associated with the drug. Click (select) to select an RxNorm. If RxNorms are not already imported, you will be prompted to import them.

**Edit a Medication**
To add a generic medication, click **Add Generic**. To add a brand name, select the generic medication, then click **Add Brand**. To edit an existing medication, double-click it.

**RxNorm**: Click [...] to associate the medication with a normalized RxNoms drug name. For EHR, all medications in your
list should be attached to an RxNorm so that the medication, and any allergies to this medication, show on EHR Summaries of Care(445).

**Drug Name**: Enter the drug name as it will show in the master list.

**Generic Name**: Enter the associated generic drug name. When entering a brand name drug this field is auto-filled with the generic name.

**Notes**: Only allowed on generic medications. Every medication should have a note, no matter how short. They usually consist of the therapeutic category, and any precautions or interactions to be aware of. All medications attached to the generic medication will show the same note.

Entering medications into the list will take a little extra time at first. It helps to divide the task among the assistants and the dentists. The assistants can look up the medication, ensure that the spelling is correct, and enter the generic and brand names. But they should not enter in any notes. Notes should only be entered by a dentist.

**Dependencies**: Click a dropdown to quickly view associated information about this drug.

- **Patient medication**: A list of all patients who have this medication ([Medications](470) (active or discontinued)).
- **Patient allergy**: A list of all patients who have this medication as an allergy ([Allergies](472) (active and inactive)).
- **Brands**: For generic medications, click the down arrow to see which brand name medications are associated with this medication.

**Delete**: Remove the medication from the master list. Medications in use by a patient, in the Allergy List, or as an EHR indicator cannot be deleted.

**Missing Generic/Brand Tab**
This tab shows for United States only. The medications in this list are imported from Legacy eRx(349), not created in Open Dental, and have likely been created in the Legacy eRx interface. This list will be empty if Legacy eRx has not been used.

To convert a medication to generic:
1. Select the drug description, then click **Convert to Generic**.
2. In the Edit Medication window, enter the medication details.
To convert a medication to brand:
1. On the All Medications tab, select a generic drug description.
2. Click the Missing Generic/Brand tab. Select the drug to convert.
3. Click **Convert to Brand**.
4. In the Edit Medication window, enter the medication details.
5. Click OK to save.

### Pharmacies

In the **Main Menu**(592), click Lists, Pharmacies.

Alternatively, in the **Edit Rx**(333) window, click Pick.

A pharmacy can be attached to prescriptions when they are called in.

Click **Add** or double-click on an existing pharmacy to edit.
Problem List
In the MainMenu(592), click Lists, Problems.
Alternatively, in the Medical (466), Problems tab, click Add Problem.

The master problem list contains all problems that can be attached to a patient’s problem list. Problems are medical conditions or other factors that affect the health of patients.

**Search:** Filter the list by ICD9, ICD10, or SNOMED CT code, or by description. As you enter criteria, the list will update with matching results.

**Sort Options:** If accessed via the main menu, problems can be reordered or sorted alphabetically.
- Use the Up/Down arrows to reorder individual problems.
- Click Alphabetize to sort the current list of problems alphabetically by description.

**Show Hidden:** When accessed via the Lists, Problems menu, problems marked Hidden show in the list by default. To unhide hidden problems, uncheck Show Hidden.

**Add or edit a problem**
To download code systems to associate to problems, see Importing Code Systems (726).

For EHR:
- Problems assigned to patients must be associated with a SNOMED CT. This causes it to show on a Summary of Care.
- If you create a none problem, also select this problem as the Indicator that patient has no problems in Chart Module Preferences (706).
Click **Add**, or double-click a problem to edit.

Problems can also be added to the master list while editing a *Medical History Sheet*(1165).

**ICD-9 Code**: Click [...] to associate the problem with an ICD-9 Code. See *ICD-10 Codes*(129).

**ICD-10 Code**: Click [...] to associate the problem with an ICD-10 Code. See *ICD-10 Codes*(129)

**SNOMED CT Code**: Click [...] to associate the problem with *SNOMED CT Codes*(727).

**Description**: Enter the identifying name of the condition.

Click OK to save the problem.

**Remove a problem**

To delete a problem, click **Delete** on the Problem Def Edit window. Problems attached to patients cannot be deleted. Instead, you can hide the problem so it is no longer a selection option for patients. Check **Hidden**.

**Providers**

The Provider List contains the profiles of doctors and hygienists in your practice.

In the *Main Menu*(592), click Lists, Providers.
Create providers and enter provider information (ID numbers, provider defaults, appointment colors, etc.) You can also create security user profiles and move patients from one provider to another.

All providers set up are listed, as well as their user name and how many patients for whom they are the primary (PriPats) or secondary (SecPats) provider. The provider order shown here determines the order in which providers show in various lists throughout the program. Available providers in those lists may be filtered by Clinic (1505).

**Search:** Enter search term to filter the provider list. Will search by first name, last name, and abbreviation.

**Show Patient Count:** Check to view PriPats and SecPats columns. Counts the number of primary and secondary patients associated to a provider.

**Show Hidden:** Check to view providers that have been marked Hidden from the Provider (1255) window.

**Show Deleted:** Check to view providers that were removed during a Provider Merge (1408).

**Add:** Click to create a new provider. Enter provider details on the Provider window. Double-click an existing provider to edit.

- **Note:** Providers cannot be deleted. Instead mark them hidden on the Edit Provider window. This will remove them as a selection option.
- If using Dental Schools, additional dental school instructor, student, and provider information shows. See Dental School Providers (1260).

**Create Users**
Quickly assign a provider to a security user group user group and create a user name and a temporary password. The Security Admin security permission is required. The user name and password will be the provider's last name plus first initial (e.g. SmithJ).

1. Select the provider.
2. Under Create Users, select the **User Group**.
Providers should log in and change their password to something only they know. If using Clinics, see User Edit(1109) to set a default clinic or restrict a user to clinics.

**Move Patients**
Change or remove providers for a group of patients. The Security Admin security permission is required. Check **Show Patient Count** to view each provider's total number of patients.

- PriPats: The number of patients for which the provider is selected as the primary provider.
- SecPats: The number of patients for which the provider is selected as the secondary provider.

**Change primary provider for a group of patients:** The Patient Primary Provider Edit permission is also required.
1. Highlight the current primary provider.
2. Under Move Patients, click [...]. Select the new primary provider and click **OK**.
3. Click **Move Pri**.
4. Click **OK** to confirm the move. The patients will now have the new provider as their primary.

**Change secondary provider for a group of patients:**
1. Highlight the current secondary provider.
2. Under Move Patients, click [...]. Select the new secondary provider and click **OK**.
3. Click **Move Sec**.
4. Click **OK** to confirm the move. The patients will now have the new provider as their secondary.

**Remove a secondary provider from a group of patients:**
1. Highlight the provider.
2. Under Move Patients, click [...].
3. Click **None**.
4. Click **OK** to confirm the move. This provider will no longer be assigned as the secondary provider to any patients.

**Reassign by most-used provider:** Quickly change a patient's primary provider to the provider who has completed most of the patient's procedures. This process will look at all patients who have the selected provider(s) as their primary provider. If a different provider has performed more of their completed procedures, that provider will be assigned as their new primary provider. The Patient Primary Provider Edit permission is also required.
1. Highlight the provider(s) to review.
2. Click **Reassign**.
3. A confirmation message will show. Click **OK** to proceed and search for possible reassignments.
4. A message will show indicating how many possible reassignments have been identified. Click **OK** to reassign the patients to the most-used provider. Click **Cancel** to abort.

Note: If multiple providers share an equal number of completed procedures, the most recently used provider will take precedence.

**Reorder the Provider List**
Changing the order does not harm any patient data. To manually reorder providers:
1. Highlight a provider.
2. Click the Up or Down arrow to move the provider one row higher or lower.

**Alphabetize Providers:** Click to alphabetize providers by abbreviation in the following order. The Provider Alphabetize permission is required.
- Providers who are people
- Providers who are marked *Not a Person* (e.g. a billing entity)
- Hidden providers
Provider

The Edit Provider window is where provider information is entered.

To open, in the Main Menu, click Lists, Providers. Click Add or double click an existing provider to edit.

The window is divided into three tabs: General, Supplemental IDs, and Web Sched. A description of all options on this window is below.

**General Tab**

Note: If viewing information for a provider that has been removed due to a merge (deleted), all fields are viewable only, not editable.

**Provider ID**: A system generated unique identifier that is useful for third party reporting.

**Abbreviation**: A short abbreviation that will identify the provider in various lists throughout the program. There is a 255 letter limit. May be changed at any time.
SSN or TIN: Enter the number used for billing purposes. Most offices will enter their TIN.

State License Number: The Provider's state license number.

DEA Number: The DEA Number associated to the provider. Only required when sending prescriptions.

State Rx ID: The provider’s state assigned Rx ID. Only required when sending prescriptions.

For providers with multiple DEA numbers or Provider IDs (e.g. a DEA number for clinics in different states), click Edit to enter numbers per clinic. Click in a cell to enter the number where required.

Medicaid ID: Only required when billing to Medicaid.

National Provider ID: (aka NPI). On an Electronic Rx (eRx) (349), you must use an individual provider NPI, not the organizational NPI. If you have a separate Facility NPI, you can create a separate provider profile for the facility. Enter the facility name as the Last Name, and check the 'Not a Person' box. To set the facility as the default practice or clinic billing provider (and thus use the facility NPI), select the facility as the default insurance billing provider in Practice or Clinic Setup.

EHR Key: (Version 14.2 and earlier). Only visible when EHR is turned on. Click [...] to enter the EHR Annual Provider Keys (723) provided by technical support. This key is required to access EHR Measure Calculation reports, and is used for CPOE and Electronic Prescription measures.

Term Date: The date when the provider will no longer be active. After the term date has ended, the provider will be unable to schedule or complete appointments, create prescriptions, or send new claims.

Appointment Color: The background color on the schedule for the provider's appointments, time bar, and operatory. Click the box to select the color. Hint: Lighter colors help black text show more clearly.

Highlight Outline Color: The color of the outline that surrounds appointment information for this provider. The outline only shows when the appointment is selected.
**EHR Meaningful Use:** EHR only. Determines which measures show in reports and on the dashboard when this provider is the primary provider. There are four options:

- **Use Global:** Use the global meaningful use stage set in EHR Settings (711).
- **Stage 1:** Show stage 1 measures.
- **Stage 2:** Show stage 2 measures.
- **Modified Stage 2:** Show EHR Modified Stage 2 measures. This is the recommended setting for 2017.

**Claim Billing Prov Override:** Optional. Select a non-person entity (set up as a non-person provider) that will be set as the default billing provider on claims when this provider is the treating provider. The claim billing provider will override the Default Insurance Billing Provider set in Clinic or Practice setup. Example: Set the practice or a treatment category for a billing override.

**Hourly Production Goal:** Set an hourly production goal for the provider ($0.00). This value will be used to calculate the daily production goal for all scheduled providers that shows in the Appointments Module (1). See Production Totals (15).

**Fee Schedule:** The provider’s default fee schedule (e.g. the UCR fee schedule).

**Specialty:** The provider’s specialty. Customize options in Definitions: Provider Specialties (886).

**Scheduling Note:** When the user clicks on an operatory header in the appointment schedule on a day the provider is scheduled, text entered here will display in the operatory header dropdown next to the provider’s scheduled time.

**Custom ID:** A user-editable unique identifier that is useful for third party reporting.

**Taxonomy Code Override:** If you enter a Taxonomy Code it will override the specialty.

**Anesthesia Provider Groups (optional):** Assign the provider to an anesthesia group. If assigned, this provider will populate the corresponding dropdowns in the Anesthesia (951) record.

**Secondary Provider:** Mark the provider as a hygienist.

**Signature on File:** Indicate whether or not the provider has a signature on file. May affect what shows on the ADA 2012 Claim Form (644) for treating provider signature.

**Not a Person:** Check this box to mark the provider as an entity or organization instead of a person. Then enter business ID numbers instead of personal ID numbers. Useful when offices want to use practice or facility as the provider on claims.

**Hidden:** Remove this provider as a selection option in various areas of the program (e.g. for providers who are no longer with the practice). Their schedule will be deleted and an X will show in the Hidden column of the Providers List. The provider will still be a selection option in standard reports. Hidden providers cannot access eRx. This will not affect scheduled appointments.

Note: Providers associated with an Appointment View cannot be marked hidden. See Appointment View Setup (621) to remove them first.

**Hidden on Reports:** Remove this provider as a selection option in Standard Reports (1278). An X will show in the Hide on Reports column of the Providers List.

**Use Electronic Prescriptions (eRx):** Enable Electronic Prescriptions for this provider. There are per provider fees. Once enabled, a provider must still complete identity proofing before use. Contact support for assistance. Unchecking this box will disable eRx for this provider.

**Allow Legacy eRx Option:** Enable if provider is still using Legacy eRx (349). Useful for offices transitioning between the legacy option to DoseSpot.

**Supplemental IDs Tab Supplemental Provider Identifiers:** Store provider IDs assigned by insurance companies, especially Blue Cross/Blue Shield. When you bill an insurance company using this payor ID, the assigned ID will show on the claim.
Click **Add** to create a new supplemental ID.

**Payor (Electronic) ID:** The payor ID of the carrier. This is case sensitive and must match the **Electronic Payer ID** list exactly.

**Type:** Type of supplemental ID. Informational only.

**Assigned ID Number:** The supplemental ID number assigned.

Click **OK** to save.

Click **Delete** to remove a number.

**Web Sched Tab**
Enter a provider description and photo that will show in the **Web Sched Recall** and **Web Sched New Patient** interface when patients are allowed to select their provider.
Description: Enter the provider description.

Picture: Click [...] to select a picture file on your computer. Click None to clear a picture selection.

Note: To allow patients to select a provider, see Setting up Web Sched Recall(1600), Setting up Web Sched New Patient(1586)

Clinics Tab
Provider clinic associations set in this tab will determine which providers show in the provider selectors for those clinics.
When set to **All**, the provider will be available to be selected for any clinic. If specific clinics are associated to the provider, the provider can only be selected at those clinics.

Providers can also be set to show or not show if they are associated to a clinic-restricted user in security setup. Even if the provider is associated to a clinic in the provider setup window, the provider's user must also have access to that clinic for any other user to select that provider, even if the other user is not restricted. For restricting users to specific clinics please see: [User Edit](1109).

**Dental School Providers**

In the [Main Menu](592), click Lists, Providers.
All provider types can be added and edited in the Provider List.

For Dental Schools (808), there are three types of providers:
- **Dental School Instructors** (1261): Can create student evaluations.
- **Dental School Students** (1263): Usually have less security permissions.
- Other providers (see Providers (1252)).

To define the security permissions each type has, see Dental School Security (1120).

By default, all providers are listed.
- If a provider is an instructor, an X shows in the Instructor column.
- To view providers that have been marked Hidden on the Edit Provider window, check Show Hidden.
- To view providers that were removed during a Merge Providers (1408), check Show Deleted. The deleted providers will be highlighted red and their information can be viewed but not edited.

To filter the list, use the Dental Schools Search by area in the upper right corner.
- **Classes**: Show student providers from a specific Dental Class (1232).
- **Radio Buttons**: All = show all providers; Students = show all students in all classes; Instructors = show all instructors.
- **Last name, First Name, Prov Num**: Enter specific criteria. The list will filter as you type.

### Dental School Instructors

In Dental School Providers (1260), click Add or double-click on an existing Instructor to edit.
Dental Schools (808) instructors are providers who can also fill out Dental Student Evaluations (1439). You must set the Dental School Setup (896) before you can create instructor providers. Existing providers or students cannot be designated as instructors. Instead you must create a new instructor.

Dental school specific information shows in the lower right corner of the window. For instructors, the Is Instructor checkbox should be checked.

In the dental schools search by area, click the Instructors radio button. Only instructors will list in the providers grid.

Enter the instructor’s information. Refer to Provider (1255) for detailed information about each field.

In the Dental Schools area, enter the user name and password this instructor will use to Log On (1121) to Open Dental.
- **ProvNum**: Automatically generated by Open Dental once a provider is added and cannot be changed.
- **User Name**: Defaults to the next available ProvNum, but can be manually edited.
- **Password**: Enter a password of your choosing. If you return to this window later, the password field will be blank. To keep the password the same, leave it blank.

By default, this instructor will be assigned to the Default User Group for Instructors (896).

Instructors can change their own password via the Main Menu, File, Change Password.
**Dental School Students**

In Dental School Providers(1260), click Add, or double-click on an existing Student to edit.

**Dental Schools** (808) students are providers who can use Open Dental for charting, but may have restricted security permissions. You must create Dental School Classes (1232) and set the Dental School Setup (896) before you can create student providers.

If you required you can filter providers in the Dental Schools Search by area:
- Select the Class the student is part of.
- Click the Students radio button.

Enter the student information:
- **ProvNum**: Automatically generated by Open Dental once the student provider is created. Cannot be changed.
- **Class**: The dental class of the student.
- **Last Name/First Name**: The student's name as it will show in Open Dental.
- **Abbr**: By default, the first four characters of the last name and first initial of first name are used. Can be changed and does not need to be unique.
- **UserName**: Defaults to the student's ProvNum but can be manually changed.
- **Password**: Enter a password of your choosing. If you return to this window later, the password field will be blank. To keep the password the same, leave it blank.

By default, this user will be assigned to the default user group for students.

Click OK to save.

Change Passwords: Students can change their own password via the main menu, File, Change Password.

Change operator and appointment colors for students: See Dental Student Bulk Edit (1264).

Editing Students: You can change student information following steps 1 - 2 above, then double clicking on the student. Or, to access the student's Provider (1255), select the All radio button on the Provider Setup window, then double click the student.
Dental Student Bulk Edit

In the MainMenu(592), click Lists, Providers(1260), Student Bulk Edit.

For Dental Schools(808), use the Student Bulk Edit tool to edit appointment and operatory colors for multiple students at once.

By default, all students will list. To filter students, you have two options:

- **Classes**: Click the dropdown to select a dental class.
- **ProvNum**: Enter a specific ProvNum.

Highlight the student(s) whose colors will be changed.

Single click on a color block next to Appointment Color or Highlight Outline Color to select a color. Then click Save to apply the color selections to the highlighted students.

Click Close to save your changes and exit the window.

Rx / Prescriptions List

In the MainMenu(592), click Lists, Prescriptions.
Use the prescription list to create templates for prescriptions that your practice commonly writes. The template can include dosage, refills allowed, notes, and drug interaction alerts based on medications, problems, and/or allergies. Templates can be freely deleted or changed without changing any patient data. You can also write prescriptions that are not in this list, so you do not need to add every possible prescription.

Related Links:
- Rx Layout(1181)
- Rx Multiple Layout(1184)
- Rx / Prescription(333)
- Rx Manage(337)

Do not copy the above list for your own use without properly researching each item.

(optional) Check Procedure code required on some prescriptions to enable the preference behavior. See Rx / Prescription(333), Procedure Code Required on Prescriptions for detailed instructions

Click Add New to create a new prescription. To copy an existing template, select the prescription, then click Duplicate.
Enter the prescription details.

- **Drug**: The name of the drug.
- **Controlled Substance**: Check this box to display the provider’s DEA# on the printed prescription.
- **Is Proc Required**: Check this box to enable this preference automatically on the Edit Rx every time this drug is prescribed. See Rx / Prescription (333). Useful for states that require a procedure code on prescriptions.
- **Sig**: Directions for the preparation and use of the drug.
- **Disp**: How much of the drug to dispense (e.g., how many tablets, volume).
- **Refills**: Number of refills allowed.
- **RxNorm**: Click [...] to select a normalized RxNorms (735) drug name.
- **Notes**: This is only for your use and not designed to go on the patient prescription.
- **Patient Instructions**: Instructions to the patient on how the medication should be taken.

(optional) Create interaction alerts based on problems, medications, and/or allergies. The alert will trigger if a patient has the problem, medication or allergy and you write a prescription using this template. See Rx / Prescription Alert (1267).

Click OK to save.
Rx / Prescription Alert

Open Dental drug interaction alerts occur when you write new paper Rx / Prescription(333) using a template that has interaction alerts set up. Interaction alerts can be based on a medication, allergy, and/or problem. They are always enabled and you cannot turn them off. Set the behavior of alerts by adding or removing alert rules in a prescription template.

EHR users: In EHR Measure Reports(434), paper prescriptions for permissible drugs count towards the denominator, but not towards the numerator. Thus, only rely on paper prescriptions and its drug interaction checks if you qualify for the e-prescribing exclusion (write less than 100 prescriptions).

Triggering Alerts

For alerts to be triggered, two conditions must be met:
1. The patient must have the problem, medication, or allergy.
2. You must create a paper prescription using the template that contains the alert.

When you select the template, the check will occur and the alert message will show.

High significance alerts are always triggered. To also show low significance alerts, uncheck Only show high significance Rx alerts in EHR Settings(711).

Set Up Alert Rules

Alert rules are created in a prescription template. To ensure alerts work correctly, make sure the Problem List(1250), Medications List(1246), and Allergy List(1221) do not contain duplicates.

1. In the Main Menu(592), click Lists, Prescriptions(1264).
2. Click Add to create a new prescription template, or select an existing one.
3. Enter or verify the prescription information.
4. Create the alert. Click Problem, Medication, or Allergy, then double click an item to select it from the master list.

To set up alerts for a category of drugs, add an alert for each medication in the category that you might prescribe. For example, if you add an allergy to NSAIDs, you might add alerts for Aspirin, Ibuprofen, and Naproxen. Each item you select will list in the Alert box.

5. To review the conditions that will generate the alert, or to customize the alert message, double click on the alert.
To customize the message, enter it as the alternate. If this is a High Significance alert, check the box. Click OK to save.

6. Click OK to save the prescription template.

**Referral List**
Maintain a list of all patient referral sources in the Referrals list.

In the **Main Menu** (592), click Lists, Referrals.

The **Select Referral** grid shows a list of all patient, non-patient, and provider referrals.

**Last Name:** The last name of a referral source or referral source description (i.e. Internet Search).

**First Name:** The first name of a referral source.

**MI:** The middle initial of a referral source.
**Title:** The provider title of the referral source (e.g. DDS or DMD).

**Specialty:** The specialty of the referral source, if a provider (e.g. Ortho, Surgery, etc).

**Patient:** X indicates a patient.

**Note:** Notes specific to the referral source.

### Add / Edit Referral Source

Enter a referral name/description in the **Search** field to find a specific referral source. Use the **Show** filters to filter the list by referral type.

- **Patient:** Show referrals who are also existing patients (marked X in the Patient column).
- **Doctor:** Show referrals marked as **Is Doctor**.
- **Other:** Show referrals that are not patients or provides marked as **Not Person**.
- **Preferred Only:** Show referrals marked as preferred. Checked by default if preference is turned on in [Family Module Preferences](#)(637).
- **Show Hidden:** Show referrals that are marked **Hidden**.

Once the referral is found double-click to open the Edit Referral window and edit the information or if the referral does not exist, click **Add** to create the referral source. If adding, click Yes or No when prompted if the referral is an existing patient then select the patient or proceed to enter the referral information in the Add Referral window.

![Edit Referral Window](image)

**Note:** If the referral is a patient, some fields can only be edited from the [Edit Patient Information](#)(62) window.

- **Hidden:** Check to hide this referral from the Referrals list.
- **Not Person:** Check if this referral is not a person (e.g. yellow pages).
**Last Name/First Name/MI:** Enter the referrals name. If a patient, this defaults to the patients last name. If not a person, enter the referral description in the last name field and leave the first name blank.

**Is Doctor:** Check if this referral is a provider. To send provider referrals electronically, Is Doctor must be checked and Not Person unchecked. See [Edit Claim - General Tab](#) (213).

**Specialty:** Select the provider's specialty.

**Title:** The provider's title.

**Address/City/State/Zip:** The mailing address for the referral.

**Phone/Other Phone:** The contact number for the referral.

**Email:** The email address for the referral.

**Email Trust for Direct:** For [Direct Messaging](#) (1666) (EHR). Check to indicate when direct trust is established with this provider. When you click OK, Open Dental will attempt to locate the provider's email certificate public key (based on the email address). If the public key is found, it will be stored in the local certificate store and Direct trust will be established. Patients referred to this provider will then be able to transmit a summary of care to the provider using the Patient Portal. If the public key is not found, you will receive a message that it cannot be located. In this case, uncheck the box since Direct trust is not established. If unchecked, patients referred to this provider will not be able to transmit a summary of care using the portal.

**SSN/TIN:** SSN or TIN of the referral if a provider.

**Note:** Notes will show in the attached referrals for a patient.

**Referral Slip:** Assign a custom [Referral Slip Layout](#) (1180). The custom slip will be the default slip generated when this referral is selected. To generate a referral slip for a patient, see [Referral Slip](#) (79).

The **Use By Patients** section shows a count of patients that have been referred to or referred from this referral source. As the referral is attached to patients, the information is automatically updated. Use the dropdown menus to see a list of patients this referral is attached to. For more referral tracking options, see [Referrals](#) (76), Track Referrals.

Click **OK** to save the referral information.

**Advanced Users**

The information shown on the form above is kept as a copy in the referral table. The reasoning behind this is that it makes reporting much simpler than having to make multiple joins between tables and handle conditional situations.

**State Abbreviations**

In the [Main Menu](#) (592), click Lists, State Abbreviations.
State abbreviations are used to enter state information in the Edit Patient Information(62) and Add Family(1652) windows. The State Abbreviations list contains U.S. states and standard abbreviations by default, but can be edited or added to. Typing the first letter of the state will prompt a suggestion box of all state abbreviations that match the first entered letter.

Note: State abbreviations are used to validate data entry of state information when State is a Required Field(71).

You may enter any description and abbreviation of your choosing, but we recommend using the standard abbreviations for states, providences, countries, etc. To add or edit state abbreviations, a user must have the Setup security permission.

The Medicaid ID Length column only shows if validation for Medicaid ID has been turned on in Required Fields Setup.

Click Add, or double click an existing state to edit.

Description: Enter an identifying name.

Abbreviation: Enter the abbreviation that will show as a selection for this state. If State is set as a required, the entered state must match a valid two-letter abbreviation in this list.
**Medicaid ID Length:** Enter the number of digits in the Medicaid ID for this state. This field only shows if validation for Medicaid ID has been turned on in Required Fields setup.

Click **OK** to save.

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**Site List**

In the **Main Menu** (592), click **Lists, Sites**.

The Site List is a list of sites used in **Public Health** (71) and by mobile clinics to track grade schools, nursing homes, etc. Sites can be assigned to patients and to procedures (**Procedure - Misc Tab** (315)). If you assign a site to a patient, it will automatically be assigned to all the patient's future procedures. Changing a site will not affect previous procedures. In **Miscellaneous Setup** (921), there is an option to show the site in the main title bar of Open Dental.

Sites is only available when Public Health is enabled in **Show Features** (806).

Sites should not be used to track fixed location dental offices. Use **Clinics** (1505) instead. Clinics and sites can be used together. For example, if you have multiple mobile units, each mobile unit would be a clinic, and each location where they park to provide treatment would be a site.

Click Add or double-click an existing site to edit.
Description: Enter the site name.

Place of Service: Click the dropdown to select the default place of service on claims when this site is associated to a procedure (see Claim(208)).

Provider: Click the dropdown or [...] to select a provider. Click None to clear a selection. This provider determines the NPI number that is sent in 5010 dental e-claims when this site is associated to a procedure on the claim. To send the site's NPI number, first create a provider for the site, mark it as 'not a person', then assign it to the site.

Address, City, St, Zip: Enter the site's address, city, state and zip.

Notes: Enter any site notes.

To send the site's place of service, NPI#, and address on claims?
1. Create a provider that is not a person and for NPI enter the site's NPI.
2. For the site: Assign the provider as the default provider. Set the default place of service (not office). Enter the site's address.
3. Assign the site to at least one procedure (Procedure - Misc Tab(315)).
4. Create the claim.

Technical Details
The site table replaces the earlier school table, most notably in the patient. Grade School field, which is now patient. SiteNum and is an int foreign key rather than a text field.

Note: For 5010 dental e-claims, the place of service on the claim cannot be office and the site provider cannot be the same as the billing provider.

Zip Code List
In the **Main Menu** (592), click Lists, Zip Codes.

The Zip Code list is a list of common zip codes, associated to a city and state. This list can simplify your data entry when entering patient information.

Typically, you will add zip codes to the list directly from the Zip Code field on the **Edit Patient Information** (62) window.

**Add a Zip Code from the Edit Patient Information window**

On the Edit Patient Information window, enter the new zip code in the Zip Code field.

Press **TAB** or click **Edit Zip**.
Verify the Zip Code, then enter the associated City and State.

**Used Frequently**: Check this box to add this zip code to dropdown on the Edit Patient Information window.

Click **OK** to save.

**Add a Zip Code via the Zip Code Master List**

Click **Add**.

Enter the Zip Code, City, and State.

Click **OK** to save.

Click the header of any column to order the list.

**Edit a Zip Code**

On the Edit Patient Information window:
- Select or enter the zip code.
- Click Edit Zip.

- Click Edit to open the Edit Zip Code window.
- Edit the zip code, state, city, or Used Frequently status as needed.
- Click **OK** to save.
From the Zip Code List:
- Double-click the zip code.
- Edit the zip code, state, city, or Used Frequently status as needed.
- Click OK to save.

Delete a Zip Code
On the Edit Patient Information window:
- Select or enter the zip code.
- Click Edit Zip.

- Highlight the city associated with the zip code.
- Click Delete.

From the Zip Code List:
- Select the zip code.
- Click Delete.
- A confirmation message will show. Click Yes to proceed.

Reports
Open Dental has many report options accessed from the Main Menu(592) that allow you to view your data in organized formats.

Standard Reports(1278): Standard, text based reports (production and income, daily and monthly reports, lists, and public health options). Optionally, run Production and Income Reports on a report server (see Report Setup: Report Server(1094)).

Graphic Reports(1376): Visual graphic reports by provider or clinic and customizable to fit your requirements (production and income, accounts receivable, new patients, and broken appointments).

User Query(1382): Generate custom reports in any format and export any data you want.
- Open Dental has a few built in queries to list tables.
- There are over 1000 query examples that you can copy and paste for use. See Query Examples.
- Write your own queries.
- We can write custom queries for you. See the Query Request Form.
**Unfinalized Payments** (1303): Shows the number of outstanding unfinalized payments in parentheses e.g. (3). Click to open the Unfinalized Payments report. Payments must be finalized for reports to be accurate.

Other Options:

- To add a click-able URL as a Reports menu option, see **Custom Bridges** (938).
- Appointment Lists (26)
- Accounting reports (General Ledger Detail and Balance Sheets). See **Accounting Close Year** (553).
- Clearinghouse reports. See **Send Claims** (489).
- Arizona Reports

**Troubleshooting**

Unfinalized Payments: If unfinalized payments are not showing in the menu item, make sure the OpenDental Service is installed in the **Service Manager** (1412).

Custom Reports: Some users may have a Custom Reports menu item. This is part a deprecated report system. It means there is a reports folder in your A to Z Folders (typically Reports) that contains at least one .rdl file (e.g. Unsched Treat Plans.rdl). For each .rdl file in the folder, there will be one menu item.

**Laser Labels**

In the **Reports** (1276) window, click the Laser Labels button.

See **Labels** (1708) for instructions on printing individual labels.
This Laser Labels feature was added entirely by Kapricorn Systems, Inc. Labels are printed 2.75 x 1 in. with a .05 in. margin on the top, left, and right and no margin at the bottom. It is assumed the paper size is 8.5x11.

Standard Reports
In the **Main Menu** (592), click **Reports** (1276), Standard.

**Setup** menu: Set up and customize defaults and user access for standard report. Options include:
- **Display Settings** (1090): Customize which reports list on the window.

Standard reports allow you to track and view data using standard, text-based reports. They include production and income reports, daily and monthly reports, lists, and public health options.
- **Security Permissions**: Restrict access to reports by user group.
- **Report Server**: Set up a report server to run Production and Income Reports. This can be useful for large offices to prevent lockups and slowness in a live database.
- **Misc Settings**: Set report defaults.

**User Query**: Open the Query window to run custom reports. See [User Query](1382).

**Laser Labels**: This feature was added entirely by Kapricorn Systems, Inc. See [Laser Labels](1277).

### Production and Income Reports
- **More Options**: Open the *Production and Income Report* window so you can customize report options.
- **Today**: Generate a report for today's date using default settings.
- **Yesterday**: Generate a report for yesterday using default settings. Note: If run on a Monday the report will be for the previous Friday. If you work over the weekend use More Options below to generate those reports.
- **This Month**: Generate a report the current month (1 - 31) using default settings.
- **Last Month**: Generate a report for last month (1 - 31) using default settings.
- **This Year**: Generate a report for the current year (Jan 1 - Dec 31) using default settings.
- **Monthly Production Goal Report**: 

### Daily: Common daily reports.
- **Daily Adjustments Report**
- **Daily Payments Report**
- **Daily Procedures Report**
- **Daily Writeoff Report**
- **Incomplete Procedure Notes**
- **Routing Slips**
- **Unfinalized Insurance Payment**
- **Patient Portion Uncollected Report**

### Monthly: Common monthly reports that are usually part of billing.
- **Aging of Accounts Receivable (A/R) Report**
- **Claims Not Sent Report**
- **Capitation Utilization Report**
- **Finance Charge Report**
- **Outstanding Insurance Claims Report**
- **Procedures Not Billed to Insurance Report**
- **PPO Writeoffs Report**
- **Payment Plans Report**
- **Receivables Breakdown Report**
- **Unearned Income Reports**
- **Insurance Overpaid Report**
- **Presented Treatment Production Report**
- **Treatment Plan Presentation Statistics Report**
- **Insurance Aging Report**
- **Procedures Overpaid Report**

### Lists: Common reports that pulls lists of various patient data.
- **Active Patients Report**
- **Appointments Report**
- **Birthday Report and Postcards**
- **Broken Appointments Report**
- **Insurance Plans Report**
- **New Patients Report**
- **Patient - Raw**
• **Patient Notes Report** (1360)
• **Prescriptions Report** (1360)
• **Procedure Codes - Fee Schedules Report** (1361)
• **Referral - Raw Report** (1363)
• **Referral Analysis Report** (1365)
• **Referred Procedure Tracking Report** (1367)
• **Treatment Finder Report** (1369)
• **Web Sched Appointments Report** (1371)
• **Hidden Payment Splits Report** (1355)

**Public Health Reports**: Public Health (71) reports.
• **Raw Screening Data Report** (1372)
• **Raw Population Data Report** (1373)
• **FQHC Dental Sealant Measure** (1374)

**EHR Patient Export** (1375)

**Business analytics**: Preferred business analytics service providers.
• Click a button to see more info; you won't be charged.
• If the bridge is already enabled, click a button to launch your account.
• To remove the button(s), go to Program Links (934), double click the bridge, uncheck the Enable box, then check Hide Unused Button.

**Patient Reviews**: Podium is a preferred patient review service provider.
• Click the button to see more info; you won't be charged.
• If the Podium Bridge (1047) is already enabled, click to launch your account in Dental Intel.
• To remove the button(s), go to Program Links, double click the bridge, uncheck the Enable box, then check Hide Unused Button.

**Troubleshooting**
Locked shows next to the report and when I attempt to generate it, I receive a message that I do not have permission to run it.
You do not have access to locked reports. Access is controlled by user group in Report Setup.

**Complex Report System**
In **Standard Reports** (1278), when a report is generated, in the upper left, a menu bar will show.

![Menu Bar]

**Print**: Print the report to the default printer. See **Printer Setup** (601).

Note: If needing to print a page range, set your Printer Setup to prompt before printing. In the printer settings prompt, set the page range you wish to print.

**Blue arrows**: Click the left arrow to move back one page; click the right arrow to move to the next page.

**Page numbers**: Indicates the page currently showing and total pages in report. Type in a page number and press Enter to jump to that page.

**Plus/minus magnifying glass**: Zoom in/out on the report.

**100**: Return to 100% view.
Wrap Text: Click to toggle text wrapping on/off in the selected report when printing long columns. Set the default in Report Setup: Misc Settings (1096).

Export: Save the report information as a txt or xls file.

Close: Close the report window.

Production and Income Reports
In Standard Reports (1278), in the Production and Income section, click on a report.

- **Today** or **Yesterday** will generate a Daily report using default options.
- **This Month** or **Last Month** will generate a Monthly report using default options.
- **This Year** will generate an Annual report for the current year (Jan. 1 - Dec. 31) using default options.
- **More Options** will open the report window so you can customize report options.

There are several Production and Income reports. Each summarizes information differently based on report type.
- Daily: Lists detailed information on transactions including payments, procedures and adjustments, for a single date or date range.
- Monthly: Lists production and income totals by day, for a date range. Also shows scheduled production.
- Annual: Lists production and income totals by month, for a date range.
- Provider: Lists production and income totals by provider, for a date range.

- **Note:** Large offices may want to set up a Report Server (1094) to run Production and Income Reports. This can be useful to prevent lockups and slowness in a live database.
  - If using multiple databases, see Central Enterprise Management Tool (CEMT) for running Production and Income reports.
- To control user access to Production and Income reports, see Report Setup: Security Permissions (1092). To control whether a user can run this report for other providers, see User Group (1115).
Report Type: Select the report type. Date range values will automatically change to match.

Providers: Select the providers to include, or check All to include all providers, including hidden providers that have claim payments for the report period. No Provider will include payments with an unearned type (pay splits not associated to a provider, such as prepayments).

- Note: Provider selection is only an option if the logged-on user has the Production and Income, View All Providers permission.

Include Unearned: Select this box to include unearned income. An additional column will be added for Unearned Income on Monthly, Annual and Provider reports, and the report will use a landscape orientation.

Note: This should either always be selected when running Production and Income, or never selected.

Clinics: Select the clinics to include, or check All to include all clinics. Clinic is determined by the clinic of the procedure (place of service).

- Show Clinic Info: Only an option when Daily is the Report Type. Set the default in Report Setup: Misc Settings (1096).

Checked: The clinic will show for each transaction, clinic totals will show at the bottom of the report, and the report will print in landscape mode.

Unchecked: Clinic information will not show and the report will print in portrait mode.

- Show Clinic Breakdown: Select how data is grouped. Set the default in Report Setup - Misc Settings.
  - Checked: Report will group by clinic.
  - Unchecked: Report will group by date and intermingle clinics.

Date Range: Select the report date range. Today’s Date is automatically populated with today’s date for reference. The default date range is based on the report type. To change, manually enter the From / To dates, or click the arrows to quickly change values.

- Today/This Month/This Year: Reset dates to match current day, month, year.
- Right/Left arrows: Move back or forward one day/month/year at a time.

Show Insurance Write-offs: Select when to apply insurance write-offs to production amounts. See Show Insurance Writeoffs (1290) for more details. Set the default in Report Setup - Misc Settings.

- Using insurance payment date: Apply the write-off when the insurance payment is entered.
- Using procedure date: Apply the write-off on the date of service.
- Use initial claim date for write-off estimates, ins pay date for write-off adjustments: Check to include write-off estimates and changes in write-offs in the report. The report will display and print in landscape orientation. See the example report below for descriptions of each write-off column.

Click OK to generate the report.

For a description of Toolbar buttons, see Complex Report System (1280).

Example of monthly report type:
**Production**: Work that has already been completed. Production from [Capitation (HMO / DMO) Insurance Plan](#) (120) is not included.

**Sched**: (Monthly only) Sum of fees for procedures attached to appointments that have not been set complete. Does not include work for Capitation insurance plans. Write-offs are only included if, in Misc Settings, *Monthly P&I scheduled production subtracts PPO write-offs*.

**Adj**: Adjustments made to the account.

**Write-off Est**: The write-off estimate amount in the ClaimSnapshot. ([Family Module Preferences](#) (637))

**Write-off**: Write-off amounts for PPO insurance plans. Capitation write-offs are not included.

**Write-off Adj**: The change in write-off amounts. Write-off estimate amount (Write-off Est column) minus the actual write-off amount. Amount must be more than zero to show.

**Total Prod**: The daily sum of Production + Scheduled + Adjustments - Write-offs.

**Pt Income**: The amount you have received from patient payments that are allocated.

**Unearned Pt Income**: The total amount of payments with an Unearned type (typically prepayments).

**Ins Income**: The amount you have received from the insurance company (claim payments).

**Tot Income**: The daily sum of Pt Income + Ins Income.

**Total Production**: The sum of all Production + Scheduled + Adjustments - Write-offs.

*Note*: While write-offs are displayed as a negative amount in the grid, that is only for visual emphasis. This does not result in negative amounts being subtracted in the production total using the equation defined above.
Total Income: The sum of all Pt Income + Unearned Pt Income + Ins Income.

Production and income amounts may not match Aging of A/R amounts.

Close Out Month

There’s nothing that you officially have to do to close out a month in Open Dental. All your financials roll over when the calendar changes, and so does Open Dental. There is also no close out process at the New Year(1220).

At the end of the month, you may want to check the following:
- Aging of Accounts Receivable (A/R) Report(1308) (although, this can be run as of any date)
- Production and Income Reports(1281)

If you use PPO Percentage plan types when you set up insurance plans, you have the option to track write-offs on the date of service or the date of insurance payment. By default, Open Dental applies write-offs to production when the insurance payment is made (see Report Setup: Misc Settings(1096)). The advantage to this method is that history won’t be changed if the write-offs were incorrect at the time of treatment planning. If you use this method, you should also use a global lock date to prevent users from editing previous entries (procedures, patient payments, insurance payments, adjustments, and exam sheets). The global lock date also disallows the backdating of new items. See Security Lock Dates(1122).

The following reports can be run anytime, but should be run at least once a month, if not more. They are key to keeping your insurance revenue coming in. You should make sure that claims are getting created, sent, and paid.
- Claims Not Sent Report(1312): List of claims that were generated in Open Dental, but not submitted to insurance.
- Outstanding Insurance Claims Report(1315): Claims that have been submitted to insurance, but have not been paid.
- Procedures Not Billed to Insurance Report(1318): Procedures that have been completed, but no claim has been created for.

The Billing List(507) and the Recall List(27) should also be run at least once a month. both lists are designed to not send statements or reminders to patients who have had contact within the month. Thus you can run them daily if you wish knowing that patients will have a month before they get another statement or recall reminder (you can change the default interval as well).

Production and Income

Below is a definition of terms used when discussing production and income, as well as a discussion about compensating providers by production vs income.

Definition of Terms

Production: The amount of money you expect to collect. Production is often described in terms of production for all (or a group of) patients in a date range (or on a certain date). Gross production is the sum of the fees charged the patient(s). It is a good number to compare how busy you were in different periods. Net production is gross production minus adjustments and insurance writeoffs.

Writeoffs: The difference between the insurance fee the provider is contractually obliged to charge and the provider's UCR fees. If patient insurance plans are set as PPO percentage plan types and use the carrier's fee schedule, several reports include writeoff information.

Adjustments: Reductions in charges to patients. Open Dental splits adjustments into positive adjustments and negative adjustments for data entry purposes, but they are reported together or by type. For example, a positive adjustment type might be "missed appointment" or "late charge". A negative adjustment might be "senior discount".

Income: The amount of money brought in or paid on accounts, usually described in terms of a date range. One could also call this "collections". For reporting purposes, this can be grouped into 'insurance income' and 'patient income'.


**Production or Income?** Sometimes there is confusion about whether a particular entry is production or income.

**Examples:**
- **Patient refund:** Both a negative adjustment (production) or a negative payment (income) would reduce the account balance. However, because money is entering or leaving the office, it should be entered as a negative payment so it shows as income in reports.
- **Warranty credit:** A patient comes into your office and a veneer that you applied last week has come off.
  1. You want to show the production of putting the veneer back on, so you enter the procedure like normal (chart the procedure, mark it complete). However, you are not going to collect the fee (no money exchanges hands) and you do not want the production to show in your Net Production for the day.
  2. Thus, add a negative adjustment equal in amount to the procedure fee. The gross production for the day will include the work for the veneer, but the net production will take into account the adjustment, thus making the net production for that patient zero.

It is easier to track production by provider, thus many offices use this method. To track income by provider, payments need to be properly allocated using paysplits. Also see **Refund** (194).

**Reports**
There are several **Production and Income Reports** (1281) (daily, monthly, annual, provider). Each summarizes the data differently but are comprised of the same information.

If you have insurance plans that use the PPO percentage plan type, and thus track write-offs, you have two options that affect when write-offs in reports are applied to production: using insurance payment date or using procedure date. See **Show Insurance Writeoffs** (1290) for guidance and examples.

**Note:** Production and income amounts may not match **Aging of Accounts Receivable (A/R) Report** (1308) amounts.

**Paying Providers Based on Production**
Some offices compensate providers by paying them a percentage of production. To determine provider production, run the Production and Income Report by provider, or for a single provider, for a date range.

**If you do not use PPO insurance plans:** The Tot Prod amount indicates the net production and accounts for adjustments. Set a Global Lock Date so that financial report data doesn't change over time. See **Security Lock Dates** (1122)

**If you have PPO insurance plans and know your contracted rates:** In this scenario you will know the write-off at the time of service. Run the report to show insurance write-offs by procedure date so net production (Tot Prod) for the day will also reflect the write-off. If for some reason the write-off amount changes at a later date, you will need to re-run historical reports.

**If you have PPO insurance plans and do NOT know your contracted rates:** In this scenario you will not know the write-off at time of service or the amounts entered at treatment time will be questionable. Thus you will enter (or update) the write-off when you receive the insurance claim payment. Run the report to show insurance write-offs by insurance payment date. The Tot Prod amount will not include write-offs until the insurance payment is entered. Since payments will not always be entered in the same time period as production, you may have ‘residual’ negative production. A provider's net production in any given period will be lessened by the amount of write-offs entered on insurance payments received in that period, even though the work may be from another period. This may or may not have a significant impact upon the production. This table has been omitted.

The real result here is that your writeoffs may be associated with work in a different time period. The numbers become less meaningful if you are trying to measure productivity. You can't just use procedure date because writeoffs will change as payments come in and you may overpay your providers.

**Paying Providers by Income**
Provider income can be viewed on the same Production and Income Report used to view production. There are two types of income: insurance income (Ins Income) and patient income (Pt Income). Together they equal the total income (Tot Income). Write-offs are not an issue because they do not affect income. They simply lower the amount you expect to collect (production).
There are two issues to be aware of when tracking income:
1. Payments need to be properly allocated. For more details, see Track Income by Provider.
2. Income may be received after the period in which it was earned.

Insurance Income: Insurance income is allocated when you receive the claim payment.
- If you receive the claim by procedure, the income for each procedure is allocated to the treating provider. It is very straightforward.
- If you receive the claim by total, the total payment will default to patient's primary provider but can be changed. As long as all procedures on the claim have the same provider you will be OK.

Patient Income: Patient income can be allocated when entering the payment or at a later date using income transfers. Depending on Payment Preferences, Open Dental may suggest paysplits based on the family's outstanding charges, payment amount, and FIFO logic (first in, first out, by date). It is very important to know which provider should and is getting credit for a payment. You should also develop a policy for allocating a payment to multiple providers. The daily or weekly Daily Payments Report (run by provider) can be a useful report to give to providers so they can verify the income information.

Adjustments to income: Adjustments themselves only affect production amounts, not income. If you need to adjust income, you must enter a payment. Below are some example scenarios.
- Returned patient check: Enter a negative payment to increase account balance. See Patient Refunds.
- Customer has work done, does not want to pay for it, and you have agreed to credit the fee: Enter a negative adjustment to affect production only. This will decrease the account balance.

What are the issues with reporting income by provider?
- Income may not come in at the time of service, so it is nearly impossible to say you are square with a provider unless you sign a settlement. That is, unless you make rules that say otherwise, the obligation to pay your providers a cut of the income lasts as long as your oldest balance for that provider.
- For example: Provider A performs a procedure for $1000. Insurance payment is expected to be $400, patient pays $300 immediately, and will pay the remainder after insurance pays. Insurance is billed the next day. Three weeks later the claim comes back saying that the procedure needs more information, the original prosthesis date is incorrect. One month after the procedure date, the provider's husband gets a job in Zambia and leaves immediately. The insurance payment finally arrives three months after the original procedure, and it is indeed $400. Now because we are paying based on income, you send provider A's check to Zambia. The patient moves and fails to pay the remaining $300. A year later the patient pays. Another check must be mailed to Zambia. So the ex-employee retains a claim on the Accounts Receivable for work that they did, and that can be a problem, but if it is not, this might be the way you want to compensate your providers.
- Patient payments are made before insurance pays and insurance does not pay as expected. If amounts are not the same as anticipated and differ by provider, one provider may end up receiving more payment than they produced. One way to handle this is to transfer income when insurance payments come in, but this can be time consuming.
- Patient preps. If using accrual accounting, see Accrual Basis Accounting.
  - Improperly allocated payments may bias toward the default practice provider. If the default practice provider also treats patients, payments may be improperly allocated and biased towards this provider. Why? Because the default practice provider is often the default primary provider for new patients, and the primary provider is always the default for patient payments. If you do not accurately assign primary providers or verify who payments are allocated to, the default provider may receive more payments. For example, if only defaults are used, a practice with three providers (each seeing 33% of the patients) will have more than 33% of new patients assigned the default practice provider as their primary, and thus more than 33% of payments will default to this primary provider.

To mitigate this issue:
- Train your staff to set the correct primary provider.
- Use a dummy practice provider if patients do not have assigned primary providers.
Train staff to correctly allocate incoming payment by provider. The most thorough solution is to do all of the above, then split payments by procedure.

**Collection Ratio**

**How much income am I getting compared to my production?**

You would think you can just compare income and production for a period and it will tell you what percentage of production you are collecting. Not so fast. This is problematic because it will compare different periods. The period you collect income for is not the same period the work was done in, so that ratio will have no meaning. Each incoming payment will be from an unknown period of production.

For example:

- If one patient payment was made in the period for $500 and no work was done, the ratio of the amount you collect relative to production would be 1/0 (or infinity) for that period.
- The next period the sum of patient portions is $2500, you get 10 checks in the mail totaling $3000, and $2000 is paid in the office. Your ratio is 5000:2500 or 2:1 or 200%.
- The next period the sum of patient portions is $3000 and you collect $2000. Your ratio is 2:3 or 66%.

These numbers will not help you run your business. And it does not matter if you make the period larger, unless you make it ONE period for all time, which again is not informative.

What you may be looking for is called the 'collection ratio' and is reported in units of days. It is also called an average collection period.

- **AR**=Average Accounts Receivable for period ((Starting AR+Ending AR)/2)
- **P**=Period=Length of collection period in days
- **CE**=Credit Extended = net production

Then the formula is \( \frac{AR \times P}{CE} \) and is reported in days.

If your ARStart is $5000 and your AREnd is $15000 then your average AR over the period is $10000.

If we call your production the credit extended, and count payment at time of service as collection, for a month of 30 days with the AR shown above and production (sales) of 50,000, your ratio is

\[ \frac{10,000 \times 30 \text{ Days}}{50,000} = 6 \text{ days} \]

**What does that mean to you?**

It means that you need to produce for 6 days to equal your average AR. So the lower the number, the better.

To determine you collection ration, there are a few queries you can copy, paste, then edit. See *Query Examples*.

- Query #884 Collection ratio for given month and year (version 14.3 and greater)
- Query #885 Collection ratio for given month and year (version 14.2 and greater)

**Provider Payroll Production and Income Report**

In *Standard Reports* (1278), click Provider Payroll Summary or Provider Payroll Detail.
The Provider Payroll report is a Production and Income Report (1281) that can be used to determine a provider’s net production and income. Some offices use this report to determine how much to pay their providers when the providers earn a certain percentage of net income. The calculations for determining production and income in this report were custom created for a specific use and may not apply to your office.

There are two Report Types, Summary and Patient Detail. The second column will show Day for Summary reports and Patient for Patient Detail reports.

- Summary: Lists the total production per day in the date range for all selected providers.
- Patient Detail: Lists production for each individual patient in the date range for all selected providers.

If you want to use this report:

- Make sure the calculations that determine the values in the report apply to your office. See the column descriptions below.
- Allocate all income (Insurance, Patient Payments).

Note: To control user access to this report, see Report Setup: Security Permissions (1092).

The Provider Payroll report can list total production per day (Summary) or per patient (Patient Detail). The report types are hidden by default. To show these reports, see Report Setup: Display Settings (1090).

Today's Date is automatically populated with today's date for reference.

Providers: Select the providers to include, or check All to include all providers, including hidden providers, that have claim payments for the report period. Unearned will include pay splits with an unearned type (not associated to a provider, such as prepayments). Typically this report is run for one provider at a time.

Note: The Include Unearned checkbox was removed in version 16.4. This checkbox worked similar to the Unearned provider in that it included/excluded payments with an unearned type.

Clinics: If using Clinics, select the clinics to include, or check All to include all clinics. Clinic is determined by the clinic of the procedure (place of service).

Date Range: Select the date range of the report. The default is based on the current Pay Period, if one is set up. Otherwise it defaults to one week prior to today's date.

- This Period: Reset dates to match current pay period. Pay periods must be set up.
- Right/Left arrows: Move back or forward one period at a time.
Click OK to generate the report.

**Example of a Summary Report and How Each Column is Calculated**

Columns three through seven are production, and eight through 12 are income.

<table>
<thead>
<tr>
<th>Date</th>
<th>Day/PatientDay</th>
<th>UCR Production</th>
<th>Est Write-off</th>
<th>Prod Adj</th>
<th>Change in Write-off</th>
<th>Net Prod (NPR)</th>
<th>Pat Inc Alloc</th>
<th>Pat Inc Unalloc</th>
<th>Ins Income</th>
<th>Ins Not Final</th>
<th>Net Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>03/11/2013</td>
<td>Monday</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
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<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>03/13/2013</td>
<td>Tuesday</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
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<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>03/15/2013</td>
<td>Thursday</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
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<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>03/17/2013</td>
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<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
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<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
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<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
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<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>03/19/2013</td>
<td>Monday</td>
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<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
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<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>03/20/2013</td>
<td>Tuesday</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
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<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>03/21/2013</td>
<td>Wednesday</td>
<td>0.00</td>
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</tr>
<tr>
<td>03/22/2013</td>
<td>Thursday</td>
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<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>03/23/2013</td>
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<td>0.00</td>
<td>0.00</td>
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<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
</tbody>
</table>

**Date**: The date that corresponds to the numbers calculated in each column.

**Day/PatientDay**: The day of the week that corresponds to the numbers calculated in each column. Only shows on Summary report type.

**Patient**: The name of the patient associated to all procedures, adjustments, and claim procedures. This is the actual patient on the paysplit. Only shows on Patient Detail report type.

**UCR Production**: Gross production based on completed procedures that were set complete within the date range. Does not include capitation write-offs.

**Est Write-off**: The total amount estimated write-off based on the Claim Snapshot.

**Prod Adj**: The sum all of adjustments that were created or edited within the date range. Excludes Bad Debt type adjustments.

**Change in Write-off**: The difference between the estimated write-off amount and the actual write-off (estimated minus actual).

**Net Prod (NPR)**: The sum of gross production, estimated write-off, adjustments, and change in write-off columns.

**Pat Inc Alloc**: The sum of payments entered within the date range that are attached to a particular procedure.

**Pat Inc Unalloc**: The sum of payments entered within the date range that are not attached to a particular procedure.

**Ins Income**: The sum of all received claim payments that were marked received or supplemental within the date range.

**Ins Not Final**: The sum of all received insurance payments not yet attached to a finalized claim payment, that were marked received or supplemental within the date range.

**Net Income**: The sum of the allocated patient income (Pat Inc Alloc) and the insurance income (Ins Income) columns.

**Technical Details**

UCR Production is calculated by ProcFee x (UnitQty+BaseUnits).

UCR and Est Write-off dates are based on the Procedure.DateComplete (the date the procedure was originally set complete) column instead of ProcDate.
Track Income by Provider

The steps for allocating income to providers using Production and Income Reports (1281) varies depending on whether the income is an insurance payment or patient payment. See Production and Income (1284) for a detailed discussion of the important differences between production and income.

Insurance Payments

All production entries (procedures and adjustments) have a provider. When you enter a claim payment by procedure using the EOB, the payment amounts are allocated to the provider attached to the procedure. See Finalize Insurance Payment (231).

Patient Payments

These can be a little trickier to allocate. You can allocate income when entering Patient Payments (158), or, if you don't know the correct allocation amounts at payment time, transfer income using Income Transfer (199) to fine tune amounts when you do.

Hints:
- See Payment Preferences (159) to set allocation preferences.
- In Account Module Preferences (693), set the Payment window to automatically open every time you Receive a Claim (229). Then you can fine tune provider balances using income transfers once you know how insurance has paid a claim.
- For other queries about tracking provider income, see Query Examples and filter results by provider and income.
- To catch providers who have been overpaid, run Query #101.

Version 15.2 to 17.2. The Payment Split Manager can be used at the time of payment to quickly allocate income to providers and attach procedures. Open Dental will suggest payment splits based on payment amount and outstanding charges and automatically attach procedures. You can accept, modify, delete, or add partial splits. See Pay Split Manager (202).

Version 15.1 or earlier: When you click OK, Open Dental will create payment splits by patient to the primary provider. If the amount exceeds the patient's balance, it will ask if you want to apply excess amounts to other family balances. If you click Yes, it will do so. If there are multiple providers who do the work for a single patient (e.g. a primary and hygienist), only the primary provider will receive the income.

Show Insurance Writeoffs

In Standard Reports (1278), in the Production and Income (1281) area, click More Options.

If you have insurance plans that use the PPO percentage insurance plan type (PPO Insurance Plan (114)), there are several other reports that can be used to report write-offs (e.g. Receivables Breakdown Report (1323), Daily Writeoff Report (1298), PPO Writeoffs Report (1319)).

Within the reports are options for Show Insurance Write-offs. These options affect the date of write-offs in the report.
Set the default option in Report Setup: Misc Settings (1096), Default to using Proc Date for PPO write-offs.

**Option 1. Using insurance payment date**

Apply write-offs when the insurance payment is received. We recommend this option when you do not know the write-off amount when service is completed (carrier fee schedule is unknown).

- **Advantage:** Historical reports will not be affected when the insurance payment (and write-off) is entered.
- **Disadvantage:** Net production (Tot Prod) for the day will not reflect the write-off. Instead write-offs will be counted against production many weeks after the actual work was done.

This method is used in the patient Account Module (150). Use this method if you use global lock dates.

**Option 2. Using procedure date**

Apply write-offs when the procedure is completed. We recommend this option when you know the write-off amount when service is completed (you have entered the carrier's fee schedule).

- **Advantage:** Net production for the day will reflect the write-off (production subtracts write-off amount).
- **Disadvantage:** If the write-off amount is changed when the insurance payment is entered, historical reports need to be re-run.

**Option 3. Using a combination of the initial claim date for write-off estimates, and the insurance payment date for write-off adjustments.**

Production and Income Report only. Include write-off estimates and changes to write-offs in the Production and Income report.

**Example**

Let us look at how each option affects the reporting of just one procedure in a monthly production and income report.

- Patient receives a $500 crown
- The insurance plan out-of-network fee is $300
- You will write off $200
- The patient pays $60 at the time of service
- 22 days later, the insurance pays $240

Show using insurance payment date. Write-offs are applied to production on the insurance payment date.
Show using procedure date. Write-offs are applied to production on the date of service.

(Production and Income Report only): Using both. Procedure date for write-off estimate, insurance pay date for write-off adjustment.

**Daily Adjustments Report**
In Standard Reports, in the Daily section, click Adjustments.

The Daily Adjustments Report lists Adjustments for a date range.

Note: To control user access to this report, see Report Setup: Security Permissions.

Calendar: In the first calendar select the start date. In the second calendar select the end date. Since this is a daily report, you typically only run a single date, but you can also include as large of a date range as you wish.

Providers: Highlight the providers to include in the report. Press Ctrl while clicking to select multiple providers, or click All to select all providers. Provider selection is only an option if the logged-on user has the Daily - View All Providers permission.

Adjustment Types: Highlight the adjustment types to include in the report. Press Ctrl while clicking to select multiple types, or click All to select all types, including those that are hidden in Definitions.

Clinics: If using clinics, select the clinics to include in the report.

Below is an example of the Daily Adjustments Report.
Daily Adjustments
Relaxation Dental
01/01/2018 - 08/06/2018
All Providers
All Clinics

<table>
<thead>
<tr>
<th>Date</th>
<th>Patient Name</th>
<th>Prov</th>
<th>Clinic</th>
<th>AdjustmentType</th>
<th>Note</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/29/2018</td>
<td>Jones, Mia</td>
<td>DOC1</td>
<td>Clinic A</td>
<td>BROKEN Appt - No Show</td>
<td></td>
<td>0.00</td>
</tr>
<tr>
<td>03/30/2018</td>
<td>Halpert, James, P</td>
<td>DOC1</td>
<td></td>
<td>Professional Discount</td>
<td></td>
<td>-1,000.00</td>
</tr>
<tr>
<td>04/02/2018</td>
<td>Dwyer, Andrew, C</td>
<td>DOC1</td>
<td></td>
<td>Professional Discount</td>
<td></td>
<td>-1,000.00</td>
</tr>
<tr>
<td>05/08/2018</td>
<td>Discount, Plan,</td>
<td>DOC1</td>
<td></td>
<td>Discount</td>
<td></td>
<td>-5.00</td>
</tr>
<tr>
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<td>Discount, Plan,</td>
<td>DOC1</td>
<td></td>
<td>Discount</td>
<td></td>
<td>-6.00</td>
</tr>
<tr>
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<td>Discount</td>
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<td>-20.00</td>
</tr>
<tr>
<td>05/30/2018</td>
<td>Ortho, Aurora,</td>
<td>DOC1</td>
<td></td>
<td>BROKEN Appt - No Show</td>
<td></td>
<td>0.00</td>
</tr>
<tr>
<td>07/02/2018</td>
<td>Peabody, Jack, P</td>
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<td></td>
<td>Finance Charge</td>
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<td>23.58</td>
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<tr>
<td>07/02/2018</td>
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<td>DOC1</td>
<td></td>
<td>Finance Charge</td>
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</tr>
<tr>
<td>07/02/2018</td>
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<td>DOC1</td>
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<td>07/02/2018</td>
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<td>07/02/2018</td>
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<td>DOC1</td>
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</tbody>
</table>

-1,839.99

Daily Payments Report
In Standard Reports (1278), in the Daily section, click Payments.
The Daily Payments report is a list of all Patient Payments (158) and Claim Payments (231) for a specific date or date range.

Note: To control user access to this report, see Report Setup: Security Permissions (1092).

Calendar: In the first calendar select the start date. In the second calendar select the end date.

Providers: Highlight the providers to include. Press Ctrl while clicking to select multiple providers, or click All to select all providers.
- Unearned will include payments with an unearned type (paysplits not associated to a provider, such as prepayments).
- Unearned / Prepayment (191)
- Provider selection is only an option if the logged-on user has the Daily - View All Providers permission.

Include Unearned: Select this box to include unearned payments.
Note: This should either always be selected when running the daily payment report, or never selected.

Clinics: Select the clinics to include. Only paysplits for the selected clinic(s) will be included.

Group By: Select how payments will be grouped. Provider paysplits will still show separately.
- Check: Group by payment (one line for each payment per provider or clinic. Open Dental will pick a patient from the bulk check to represent the whole amount.).
- Patient: Group by paying patient (one line for each patient per provider or clinic).
- Show splits by provider separately: Checked by default. Keep checked to split payments by provider. Uncheck to group payments.

All insurance payment types: Select the insurance payment types to include. To select specific options, uncheck All, then highlight items.
**All patient payment types:** Select the patient payment types to include. When All is checked, hidden payment types will be included. To select specific options, uncheck All, then highlight items.

Note: Income transfers list as a patient payment type. When running the report for specific providers, it is possible not all income transfers will show. To see the full income transfer, both provider associated with the transaction must be selected.

**All Claim Payment Groups:** Select the claim payment group (useful when many people enter payments at once). See [Finalizing Insurance Payments](#) (231) to assign claim payment groups. To select specific options, uncheck All, then highlight items.

Click OK to generate the report.

For a description of toolbar buttons, see [Complex Report System](#) (1280).
Daily Procedures Report

In Standard Reports(1278), in the Daily section, click Procedures.

The Daily Procedures Report lists all completed procedures within a date range. This report can be used to track quantity and production of a specific procedure, to generate a list of patients that had a specific procedure performed, or to track overall production.

Note: To control user access to this report, see Report Setup: Security Permissions(1092).

Calendar: Since this is a daily report, you typically only run a single date, but you can also include as large of a date range as you wish. In the first calendar select the start date. In the second calendar select the end date.

Providers: Highlight the providers to include. Press Ctrl while clicking to select multiple providers, or click All to select all providers. Provider selection is only an option if the logged-on user has the Daily - View All Providers permission.

Type: Choose which type of report to run.

Individual Procedures / Grouped by Procedure Code: Select how to sort and group the report.
- Individual Procedures: Lists all patients, procedures and production, ordered by date.
- Grouped by Procedure Code: Groups procedure codes together and removes patient names to show quantity and production only.

Only for procedure codes similar to: To limit the report to only one procedure code, enter the code here (e.g. D1234).
Clinics: Select the clinic(s) to report on. The default clinic is the clinic associated with the user. If user is restricted to a clinic, he can only run the report for that clinic. Unassigned refers to patients who are not assigned a clinic.

### Daily Procedures

**Relaxation Dental**  
**07/01/2018 - 08/06/2018**  
**All Providers**  
**All Clinics**

<table>
<thead>
<tr>
<th>Date</th>
<th>Patient Name</th>
<th>Code</th>
<th>Tooth</th>
<th>Description</th>
<th>Provider</th>
<th>Clinic</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>07/03/2018</td>
<td>Groundrunner, Luke</td>
<td>D2393</td>
<td>5</td>
<td>resin-based composite -</td>
<td>DOC1</td>
<td>Unassigned</td>
<td>145.00</td>
</tr>
<tr>
<td>07/03/2018</td>
<td>Moore, Harrison</td>
<td>D0140</td>
<td></td>
<td>limited oral evaluation -</td>
<td>DOC1</td>
<td>Unassigned</td>
<td>70.00</td>
</tr>
<tr>
<td>07/03/2018</td>
<td>Moore, Harrison</td>
<td>D0330</td>
<td></td>
<td>panoramic radiographic</td>
<td>DOC1</td>
<td>Unassigned</td>
<td>95.00</td>
</tr>
<tr>
<td>07/03/2018</td>
<td>Moore, Harrison</td>
<td>D1110</td>
<td></td>
<td>prophylaxis - adult</td>
<td>DOC1</td>
<td>Unassigned</td>
<td>85.00</td>
</tr>
<tr>
<td>07/03/2018</td>
<td>Peabody, Jack P</td>
<td>D7140</td>
<td>1</td>
<td>extraction, erupted tooth</td>
<td>DOC1</td>
<td>Unassigned</td>
<td>85.00</td>
</tr>
<tr>
<td>07/03/2018</td>
<td>Peabody, Jack P</td>
<td>D7140</td>
<td>16</td>
<td>extraction, erupted tooth</td>
<td>DOC1</td>
<td>Unassigned</td>
<td>85.00</td>
</tr>
<tr>
<td>07/03/2018</td>
<td>Plan, Payment</td>
<td>000</td>
<td></td>
<td>Procedure Code</td>
<td>DOC1</td>
<td>Unassigned</td>
<td>500.00</td>
</tr>
<tr>
<td>07/03/2018</td>
<td>Plan, Payment</td>
<td>000</td>
<td></td>
<td>Procedure Code</td>
<td>DOC1</td>
<td>Unassigned</td>
<td>1,000.00</td>
</tr>
<tr>
<td>07/05/2018</td>
<td>Grayson, Jack</td>
<td>D0150</td>
<td></td>
<td>comprehensive oral eva</td>
<td>DOC1</td>
<td>Clinic A</td>
<td>65.00</td>
</tr>
<tr>
<td>07/05/2018</td>
<td>Grayson, Jack</td>
<td>D0210</td>
<td></td>
<td>intraoral - complete ser</td>
<td>DOC1</td>
<td>Clinic A</td>
<td>95.00</td>
</tr>
<tr>
<td>07/09/2018</td>
<td>Moore, Harrison</td>
<td>000</td>
<td></td>
<td>Procedure Code</td>
<td>DOC1</td>
<td>Unassigned</td>
<td>1,000.00</td>
</tr>
<tr>
<td>07/09/2018</td>
<td>Moore, Harrison</td>
<td>333</td>
<td></td>
<td>333 - tooth range</td>
<td>DOC1</td>
<td>Unassigned</td>
<td>200.00</td>
</tr>
<tr>
<td>07/09/2018</td>
<td>Moore, Harrison</td>
<td>D7140</td>
<td>15</td>
<td>extraction, erupted tooth</td>
<td>DOC1</td>
<td>Unassigned</td>
<td>85.00</td>
</tr>
<tr>
<td>08/06/2018</td>
<td>Capitation, Sally</td>
<td>D2393</td>
<td>14</td>
<td>resin-based composite -</td>
<td>DOC1</td>
<td>Unassigned</td>
<td>0.00</td>
</tr>
<tr>
<td>08/06/2018</td>
<td>Capitation, Sally</td>
<td>D293</td>
<td>15</td>
<td>resin-based composite -</td>
<td>DOC1</td>
<td>Unassigned</td>
<td>0.00</td>
</tr>
<tr>
<td>08/06/2018</td>
<td>Gonzalez, Brennan</td>
<td>D6342</td>
<td>19</td>
<td>pontic - porcelain fused</td>
<td>DOC1</td>
<td>Unassigned</td>
<td>682.00</td>
</tr>
<tr>
<td>08/06/2018</td>
<td>Gonzalez, Brennan</td>
<td>D6782</td>
<td>18</td>
<td>retainer crown - porcelain</td>
<td>DOC1</td>
<td>Unassigned</td>
<td>900.00</td>
</tr>
<tr>
<td>08/06/2018</td>
<td>Gonzalez, Brennan</td>
<td>D6752</td>
<td>20</td>
<td>retainer crown - porcelain</td>
<td>DOC1</td>
<td>Unassigned</td>
<td>900.00</td>
</tr>
<tr>
<td>08/06/2018</td>
<td>Gonzalez, Brennan</td>
<td>N4127</td>
<td>Bridge Seat</td>
<td></td>
<td>DOC1</td>
<td>Unassigned</td>
<td>0.00</td>
</tr>
</tbody>
</table>

**Total: 5,999.00**

---

**Daily Writeoff Report**

In **Standard Reports** (1278), in the *Daily* section, click **Write-offs**.
The Daily Write-off Report lists write-offs by patient for a single date or date range. Write-offs are only tracked for insurance plans that use the PPO Percentage plan type. See In-network/Contracted Insurance Plans (PPOs)(114).

Note: To control user access to this report, see Report Setup: Security Permissions(1092).

**Calendar:** In the first calendar select the start date. In the second calendar select the end date. The date range defaults to today's date.

**Providers:** Highlight the Providers to include. Press Ctrl while clicking to select multiple providers or click All to select all providers. Provider selection is only an option if the logged-on user has the Daily - View All Providers permission.

**Show Insurance Write-offs:** Determines the date write-offs are applied. See Show Insurance Writeoffs(1290) for more details.
- Using insurance payment date: Apply write-offs on the date the insurance claim is received (Receive Claim(229)).
- Using procedure date: Apply write-offs on the day the procedure is completed.
- Using initial claim date for write-off estimates, insurance pay date for write-off adjustments.

**Clinics:** Select the clinics to include. Press Ctrl while clicking to select multiple clinics, or click All to select all clinics. Unassigned refers to write-offs (claims) not assigned to a clinic.

Click OK to generate the report.
**Daily Writeoffs**  
Relaxation Dental  
02/01/2018 - 08/06/2018  
All Providers  
All Clinics

<table>
<thead>
<tr>
<th>Date</th>
<th>Patient Name</th>
<th>Carrier</th>
<th>Provider</th>
<th>Clinic</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>03/20/2018</td>
<td>Gasperetti, Gary</td>
<td>Moda</td>
<td>DOC1</td>
<td></td>
<td>100.00</td>
</tr>
<tr>
<td>03/26/2018</td>
<td>Gasperetti, Emily P</td>
<td>Moda</td>
<td>DOC1</td>
<td></td>
<td>750.00</td>
</tr>
<tr>
<td>04/09/2018</td>
<td>Peabody, Rebecca</td>
<td>PPO (Preferred Provider Insurance)</td>
<td>DOC1</td>
<td></td>
<td>450.00</td>
</tr>
<tr>
<td>05/31/2018</td>
<td>Gasperetti, Gary</td>
<td>Moda</td>
<td>DOC1</td>
<td></td>
<td>250.00</td>
</tr>
<tr>
<td>06/04/2018</td>
<td>Smith, Dwight</td>
<td>ABC Insurance</td>
<td>DOC2</td>
<td></td>
<td>20.00</td>
</tr>
<tr>
<td>06/04/2018</td>
<td>Smith, Dwight</td>
<td>ABC Insurance</td>
<td>HYG2</td>
<td></td>
<td>27.00</td>
</tr>
<tr>
<td>06/04/2018</td>
<td>Smith, Angela</td>
<td>ABC Insurance</td>
<td>HYG1</td>
<td></td>
<td>27.00</td>
</tr>
<tr>
<td>06/04/2018</td>
<td>Smith, Angela</td>
<td>ABC Insurance</td>
<td>DOC1</td>
<td></td>
<td>20.00</td>
</tr>
<tr>
<td>06/04/2018</td>
<td>Gasperetti, Gary</td>
<td>Moda</td>
<td>DOC1</td>
<td></td>
<td>200.00</td>
</tr>
<tr>
<td>06/22/2018</td>
<td>Smith, Dwight</td>
<td>ABC Insurance</td>
<td>DOC1</td>
<td></td>
<td>250.00</td>
</tr>
<tr>
<td>06/28/2018</td>
<td>Gasperetti, Emily P</td>
<td>Moda</td>
<td>DOC1</td>
<td>Clinic B</td>
<td>250.00</td>
</tr>
<tr>
<td>06/28/2018</td>
<td>Plan, Treatment</td>
<td>An Insurance Carrier (PPO)</td>
<td>DOC1</td>
<td></td>
<td>500.00</td>
</tr>
<tr>
<td>06/28/2018</td>
<td>Claim Payment, Patrick</td>
<td>Metlife</td>
<td>DOC1</td>
<td>Clinic B</td>
<td>27.00</td>
</tr>
</tbody>
</table>

2,871.00

**Incomplete Procedure Notes Report**

In [Standard Reports](1278), in the *Daily* section, click **Incomplete Procedure Notes**.
This report shows all completed procedures with incomplete Procedure Notes (316) or Procedure Group Note (479), and can optionally include procedures with no note or unsigned notes.

- **Incomplete Procedure Note**: A procedure with uncompleted quotations in the Notes text (e.g. Due Date “”). Flagged with a red Incomplete Note warning above the note.
- **Incomplete Auto Notes**: Procedures with Auto Notes that have skipped prompts.
- **No Procedure Note**: The procedure has never had text in the Notes box, and all other procedures with the same date also have no note. If a procedure has uncompleted quotations any other procedure completed the same day without a note will be excluded from the list.
- **Unsigned Procedure Note**: There is a note on the procedure that has not been signed (valid or invalid signature).

Note: To control user access to this report, see Report Setup: Security Permissions (1092). To set report defaults, see Report Setup: Misc Settings (1096).

**Include procedures with no notes on any procedure for the same day**: Check to list patients with completed procedures, on the same day that does not have a note and uncompleted quotations. Note: If a procedure had a note at one time but currently does not, the procedure will be excluded from the list.

**Include procedures with a note that is unsigned**: Check to include procedures with a note but no note signature (valid or invalid). Note: If Include procedures with no notes on any procedure for the same day is also checked and no note ever existed in the procedure note field, the Unsigned column will be blank.

Use the From date dropdown menu to select the start date and the To date dropdown menu to select the end date. Includes patients matching the filter criteria within the selected date range. Defaults to today’s date.
Clinics: Highlight specific clinics, or select All to include patients for all clinics.

Providers: Highlight specific providers, or click All to include patients for all providers.

List results are ordered by completed procedure date and patient name. Select one of the following to group the list by:
- Procedure (default): Lists patients by procedure code.
- Patient: Groups by patient name (one row per patient).
- Date and Patient: Groups by completed procedure date then patient name (one row per patient, per date).

Click Refresh to update the list after making filter changes.
- Single click a patient to select the patient in the background.
- Right click or double click a patient to go to the patient’s chart.
- Print to send to the default printer.
- Export to save as a file.

Routing Slips
Open Dental is designed for use in a paperless office, but there are still some offices that like to use printed routing slips.

In Standard Reports (1278), in the Daily section, click Routing Slips.

From here Open Dental can print a batch of routing slips for all appointments for an entire day. To customize routing slips, see Routing Slip Layout (1181).

Providers: Highlight the Providers to print routing slips for. Check All to select all providers.
Clinics: Highlight the clinics to print routing slips for. Check All to select all clinics.
Date: Enter the date. Click Today to insert today’s date, or Displayed to insert the current date shown in the Appointments module.

Note: To control user access to this report, see Report Setup: Security Permissions (1092).

Routing slips can also be printed from the Appointments Module (1)

1. Right click on an appointment, then click Routing Slip.
2. Click the Print Icon. Print all routing slips for the day, or for the current view.

Below is an example of the internal Routing Slip.

### Routing Slip

<table>
<thead>
<tr>
<th>Luke Groundrunner</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>10:10 AM 05/23/2018</td>
<td></td>
</tr>
<tr>
<td>60 minutes</td>
<td></td>
</tr>
<tr>
<td>1- Smith, Ella</td>
<td></td>
</tr>
<tr>
<td>Procedures:</td>
<td></td>
</tr>
<tr>
<td>#14-MOD A3</td>
<td></td>
</tr>
<tr>
<td>Note:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient Info</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>PatNum: 100</td>
<td></td>
</tr>
<tr>
<td>Age: 40</td>
<td></td>
</tr>
<tr>
<td>Date of First Visit: 04/23/2018</td>
<td></td>
</tr>
<tr>
<td>Billing Type: Standard Account</td>
<td></td>
</tr>
<tr>
<td>Recall Due Date:</td>
<td></td>
</tr>
<tr>
<td>Medical notes:</td>
<td></td>
</tr>
<tr>
<td>Other Family Members</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Primary Insurance</th>
<th>Secondary Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Empire Ins Co</td>
<td>Subscriber:</td>
</tr>
<tr>
<td>Subscriber: Luke Groundrunner</td>
<td></td>
</tr>
<tr>
<td>Annual Max: $1,200.00, Pending: $0.00, Used: $0.00</td>
<td>Annual Max: , Pending: , Used:</td>
</tr>
<tr>
<td>Deductible: $50.00, Ded Used: $0.00</td>
<td>Deductible: , Ded Used:</td>
</tr>
<tr>
<td>Crowns 50%, Diagnostic 100%, X-Ray 100%, Endo 80%, Oral Surgery 80%, Perio 80%, Prosth 50%, Restorative 80%, Preventive 100%</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Account Info</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Guarantor: Luke Groundrunner</td>
<td></td>
</tr>
<tr>
<td>Balance: $0.00</td>
<td></td>
</tr>
<tr>
<td>-Ins Est: $0.00</td>
<td></td>
</tr>
<tr>
<td>Total: $0.00</td>
<td></td>
</tr>
<tr>
<td>Aging: 0-30:$0.00 31-60:$0.00 61-90:$0.00 90+:$0.00</td>
<td></td>
</tr>
<tr>
<td>Fam Urgent Fin Note:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Treatment Plan</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>No priority, N4127, BridgeSeat, $0.00</td>
<td></td>
</tr>
<tr>
<td>No priority, D2160, #14-MOD A3, $293.00</td>
<td></td>
</tr>
<tr>
<td>No priority, D2393, #19-MOD C3(P), $293.00</td>
<td></td>
</tr>
<tr>
<td>No priority, D6752, #29- RtcPrFN, $800.00</td>
<td></td>
</tr>
<tr>
<td>No priority, D6242, #30- PontPFNM, $682.00</td>
<td></td>
</tr>
<tr>
<td>No priority, D6752, #31- RtcPrFN, $800.00</td>
<td></td>
</tr>
</tbody>
</table>

**Unfinalized Insurance Payment Report**

In [Standard Reports](1278), in the **Daily** section, click Unfinalized Insurance Payments.
The Unfinalized Insurance Payment Report lists insurance payments that have not been finalized.

Note: Any unfinalized payments show in parentheses in the Reports (1276) dropdown, e.g. Unfinalized Payments (3).

**Type:** Select the type of insurance payments you would like to display.
- **All**: All unfinalized insurance payments.
- **Partial Payments**: Batch insurance payment not finalized.
- **Unfinalized Payment**: Single unfinalized insurance payment.

**Clinic:** Select the clinic to filter by.

**Carrier:** Narrow list down by insurance carrier.

Click **Refresh** to update the list. Click **Print** to print the report. Click **Export** to save the results as a txt or xls file.

**Net Production Detail Daily Report**

In **Standard Reports** (1278), in the **Daily** section, click **Net Production Detail Daily**.
The Net Production Detail Daily Report is a true daily report that lists net production by transaction in a specified date range. This report is useful for offices that use accrual accounting. The estimated write-off is reported on the date of service and any variance in that write-off is reported on the insurance payment date as the change from estimate to actual.

- Note: This report is hidden by default because it uses custom logic created to facilitate provider compensation. To show this report see Report Setup: Display Settings(1090).
- To control user access to this report, see Report Setup: Security Permissions(1092).

**Providers**: Highlight the providers to include in the report. Press Ctrl while clicking to select multiple providers, or click All to select all providers.

**Clinics**: Select the clinics to include in the report, or click All to select all clinics.

**Pay Period Date Range**: Default is the current pay period. Click the left or right arrow to adjust the date range of the report.

**Report Types**: Choose Date Range or Today. Date range is by pay period if one is set up.
### Technical Details

Type: There are three types that will appear.

- **Procedure Completed**: Date is based on date completed. UCR is gross production without capitation. OrigEstWO, EstVsActualWO, and Adjustment are zero by default.
- **Prod Adjustment**: Date is based on the date the adjustment was created. Bad debt types are not included. OrigEstWO, Adjustment, and NPR are zero by default.
- **Claim Received**: Date is based on SuppReceived column. UCR, OrigEstWO, and Adjustment are zero by default.

**UCR**: Gross production by day. Does not take capitation write-offs into account, and procedures attached to a primary and secondary claim will be listed twice. This may cause the gross production values to differ from the Production and Income report.

**OrigEstWO**: Write-off estimate amount for the procedure's primary insurance, based on the Claim Snapshot. ([Family Module Preferences](637))

**EstVsActualWO**: Snapshot write-off minus the claim proc write-off.

**NPR**: This is net production: gross production (UCR) minus write-off estimates (OrigEstWO).

### Patient Portion Uncollected Report

The Patient Portion Uncollected Report shows the uncollected patient balance of procedures completed in a date range.

In [Standard Reports](1278), in the *Daily* section, click **Patient Portion Uncollected**.
Note: To control user access to this report, see Report Setup: Security Permissions (1092).

**Calendar:** In the first calendar select the start date. In the second calendar select the end date. Only procedures completed in the selected date range will appear on the report.

**Clinics:** If using Clinics, select the clinics to include in the report. Users can only select clinics they have access to.

Click OK to generate the report.

The Patient Portion Uncollected report uses the Complex Report System (1280).
Below is a description of each column in the report.

- **Date**: The procedure completed date.
- **Patient Name**: The patient with the completed procedure that has a remaining balance.
- **Procedure**: The abbreviation of the completed procedure.
- **Fee**: The procedure fee (multiplied by Base Units and **Unit Quantity** if entered).
- **Patient**: The total amount the patient owes after the insurance payment and write-off.
- **Adjustment**: The total amount of adjustments attached to the procedure.
- **Patient Paid**: The total amount of patient payments attached to the procedure.
- **Uncollected**: The remaining procedure balance after any partial patient payments, insurance payments, insurance write-offs, and adjustments.

**Questions and Answers**

The uncollected amount for a procedure does not reflect the insurance estimate/payment and write-off. Why?

Procedures on sent and received claims reflect insurance estimates/payments and write-offs. Procedures on claims with any other status do not.

The account balance is at zero but the report is still showing an uncollected patient portion. Why?

Procedures must have payments specifically allocated to them or they will still show on the report.

**Aging of Accounts Receivable (A/R) Report**

In **Standard Reports**, in the **Monthly** section, click **Aging of A/R**.
The Aging of A/R report lists guarantors who owe the office money. It is based on the guarantor's billing type, primary provider and clinic. Aging (1423) is automatically recalculated when the report is generated.

Notes:
- If pay plan logic is Age Credits and Debits, payment plan due amounts are included in the A/R balance. (Account Module Preferences (693))
- To control user access to reports, see Report Setup: Security Permissions (1092).
- To set other report defaults, see Report Setup: Misc Settings (1096) (text wrapping, include patient number).

**As of Date:** Enter the as of date for the report. Defaults to the date of the most recent aging calculation (usually today). If changed to a historical date, totals reflect all transactions up to the date entered except for estimated write-offs.

**Age of Account:** Select which patients to include based on aging balance.
- Any Balance: Include patients with any balance due.
- Over 30 Days: Include all patients with balances that are over 30 days due.
- Over 60 Days: Include all patients with balances that are over 60 days due.
- Over 90 Days: Include all patients with balances that are over 90 days due.

**Group By:** Select how to group calculation amounts.
- Family (default): Group by family, listed by guarantor.
- Individual: Group by individual patient.

- Note: When grouped by family, the report includes patients with negative balances and insurance estimates by default. When grouped by individual, the user will need to manually include patients with negative balances and insurance estimates if desired. This required if you want an itemized family breakdown (see below).

**Exclude Patients With:** These options exclude selected patients in the report results. Check to enable; uncheck to disable.
- Inactive status: Do not include patients who are marked Inactive on the Edit Patient Information window.
- Archived status: Do not include patients who are marked Archived on the Edit Patient Information window.
- Bad addresses (no zip code): Do not include patients who have no zip code entered on the Edit Patient Information window.

**Include Patients With:** Include patients that meet the selected criteria.
- No selection: Only include patients with positive balances.
- Insurance estimates and no balance: Include patients with a balance of zero, but also have an insurance estimate.
Only Patients With: Select only patients who match selected criteria.
- Negative balances: Only show patients who have a negative balance (credit).
- Insurance estimates and no balance: Only show patients with a balance of zero, but also have an insurance estimate.

Age Write-off Estimates: Check to subtract write-off estimate amounts from aging category totals. Write-off estimates are aged by procedure date.

Show last payment date (landscape): Include date of last payment for patients. This will print the report in landscape.

Billing Types: Highlight the billing types to include or click All to include all billing types.

Providers: Highlight the primary providers to include or click All to include all primary providers. Provider selection is only an option if the logged-on user has the Production and Income, View All Providers permission.

Clinics: If using Clinics, highlight the clinics to include or click All to include all clinics. Only clinics the logged-on user has access to are options.

Note: When the report is grouped by family, clinic is determined by the guarantor's assigned clinic. When grouped by Individual, clinic is determined by the patient's assigned clinic.

Generate Query (optional): Click to generate the raw query text of the Aging report.

Click OK to generate the report. The Aging of A/R report uses the Complex Report System (1280).

Note: The Future dated transactions are allowed text only appears if one or more of the following Account preferences are allowed: Allow future dated payments, Allow future payments, All future dated transactions. Aging may look inaccurate if any of these preferences are allowed.

AGING OF ACCOUNTS RECEIVABLE
Relaxation Dental
As of 08/06/2018
Any Balance
All Billing Types
All Providers
All Clinics

<table>
<thead>
<tr>
<th>Guarantor</th>
<th>0-30 Days</th>
<th>31-60 Days</th>
<th>61-90 Days</th>
<th>&gt; 90 Days</th>
<th>Total</th>
<th>-W/O Est</th>
<th>-Ins Est</th>
<th>=Patient</th>
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</table>

| Total                  | 3,767.00  | 4,440.01   | 3,730.00   | 16,700.00 | 28,637.01 | 1,029.00 | 2,265.00 | 25,343.01 |
Below is a description of each column in the report. The columns will vary depending on the report criteria.

- **Patients/Guarantors:** The patients/guarantors who meet the filter criteria.
- **0-30 Days:** The balance that is 30 days past due.
- **31-60 Days:** The balance that is 31-60 days past due.
- **61-90 Days:** The balance that is 61-90 days past due.
- **&lt; 90 Days:** The balance that is greater than 90 days past due.
- **Total:** The total amount owed by the individual or guarantor, before insurance.
- **W/O Est:** The insurance write-off estimate amount based on the procedures attached to the claim. Only shows if **Age Write-off Estimates** is unchecked and there are still unreceived write-off estimates as of the report date.
- **W/O Change:** The difference between the original write-off estimate and the current write-off estimate for unreceived claims. Only shows if **Age Write-off Estimates** is checked and if the original write-off estimate changed.
- **Ins Est:** The total estimated insurance payment amount. This is the sum of all claims for the individual or family.
- **Patient:** The patient portion (Total - INS Est - W/O Est).
- **Last Pay Date:** The date of the last received payment.

### Examples

**After a Conversion:** To generate an Aging of A/R report so you can compare the total account balance in your old software with the beginning total account balance in Open Dental.

- Run the Aging of A/R report on the date of conversion. Select the date of conversion as the **As of Date**.
- Select **Include negative balances**.
- If payment plans were converted, you will need to account for payment plan due balances in the A/R. If pay plan logic is Age Credits and Debits, these amounts are reflected in the A/R balance. If not, run the [Payment Plans Report](1321) instead.

**Collections:** To make the list smaller for collections purposes filter the report by Age of Account (e.g. over 90).

To print an accounts receivable report (families with positive balances), select the following options:

- **Age of Account - Any Balance**
- **Billing Types - AllProviders - All**

To print a total practice account balance (all accounts regardless of balance), select the following options:

- **Age of Account - Any Balance**
- **Negative Balances - Include negative balances**
- **Billing Types - All**
- **Providers - All**

To match the totals of the Aging of A/R Report and Receivables Breakdown Report: See [Receivables Breakdown Report](1323).

### Questions and Answers

**Question:** I am comparing my Aging of A/R total from two dates. I expect the differences to be equal to the Production and Income amounts for the period, but it differs. **Why?**

**Answer:** If Line Item Payment Plans is not turned on, payment plans are not part of individual account balances and therefore not part of the practice balance, which is the A/R. Every time you create a payment plan you are making a loan and reducing your A/R. Likewise, payments attached to a payment plan do not change your A/R, but do affect production and income.

\[
AR1 - AR2 = (ProdT2 - ProdT1) - (IncomeT2 - IncomeT1) + (PayPlanPaymentsT2 - PayPlanPaymentsT1) - \text{Change of TP completed amounts of all payment plans.}
\]

**Question:** I am using clinics. When I run reports, the Aging of A/R report shows payment assigned to one clinic, but the Production and Income (P & I) report shows the same payment assigned to a different clinic. **Why?**

**Answer:** Each report determines the clinic differently. The Aging of A/R report determines clinic based on the guarantor’s assigned clinic (the person technically ‘owns’ the debt). The P & I report determines clinic based on the clinic assigned to the procedure (place of service).
Claims Not Sent Report

In Standard Reports(1278), in the Monthly section, click Claims Not Sent.

The Claims Not Sent report is a list of claims that have been created, but not sent. It can be generated for a single date or date range.

Note: To control user access to this report, see Report Setup: Security Permissions(1092).

From/To: Filter the report by date range. This looks at the Date of Service on the claim.

Clinics: If using clinics, highlight the clinics to include. Click All to select all clinics.

Claim Filter: Select the type of claims you would like to populate.
- WaitQ: Claims with a Waiting to Send status.
- Holding: Secondary claims with a Hold until pri received status.
- Unsent: Claims marked with the Unsent status.

Refresh: Click to update report results.

Click Run Report to print or export the list.
Note: If a claim has more than two procedures attached, you may need to click **Wrap Text** to see all procedures on the report.

For a description of toolbar buttons, see **Complex Report System**(1280).

---

**Capitation Utilization Report**

In **Standard Reports**(1278), in the **Monthly** section, click **Capitation Utilization**.

Enter a few letters of the name of the insurance carrier

From Date: 10/01/2018

To Date: 10/31/2018

This report is only useful if you use **Capitation Insurance Plans**(120). It can be run at the end of each month to show all procedures for a date range performed for capitation, along with the provider fees and the patient copay.

Note: To control user access to this report, see **Report Setup: Security Permissions**(1092).

**Carrier**: Enter a carrier name to filter the report for a specific carrier. You do not need to enter the entire name. Only procedures with carriers that match entered characters will be included in the report.

**From/To Date**: Enter the report date range. The current month is the default.

Click OK to run the report.
Procedures marked *do not bill insurance* do not show on the report.

**Finance Charge Report**

In **Standard Reports** (1278), in the *Monthly* section, click **Finance Charges**.

This report lists all **Finance Charges** (1428) applied on a selected date.

**Note:** To control user access to this report, see **Report Setup: Security Permissions** (1092).

**Providers:** Highlight the providers to include in the report, or check **All** to select all providers.

**Billing Types:** Highlight the billing types to include in the report, or check **All** to select all billing types.

**Date Range:** Enter the **From** and **To** dates. The date range defaults to the last day the finance charge tool was run.

Click **OK**.
Also see Complex Report System (1280).

Outstanding Insurance Claims Report
In Standard Reports (1278), in the Monthly section, click Outstanding Insurance Claims.

This Report is useful for tracking claims that have been sent, but not received. From here you can also update tracking status for many claims at once or delegate staff to follow-up on claims.

Note: To control user access to this report, see Report Setup: Security Permissions (1092).

Claims that meet the filter criteria will list. Click a column title to sort results in ascending or descending order. To view a claim, double click it.

Right click options: Right click on a claim row to select one of the following options:
- Go to Account: Jump to the patient's Account module without closing the report window.
- Assign to Me: Assign the claim to the logged on user.
- Assign to User: Assign the claim to any user.
Filters: If you change filter criteria, click Refresh to update list of results.

- **Days Old (min/max):** Filter by claim age. The age of the claim depends on the date type selected in the Date Range Applied to filter. Leave both fields blank to show all claims.
- **Date Range (from/to):** Filter by a date range. Use the Date Range Applies to filter to select which date type to use.
- **Date Range Applies to:** Select what date type to use when filtering the report.
  - Date Sent: The date the claim was last sent.
  - Date Sent Orig: The date the claim was originally sent.
  - Date of Service: Date of service of procedures on claim.
- **Preauth Options:** Select option for displaying Preauthorization.
  - Including Preauths: Include preauthorizations.
  - Excluding Preauths: Do not include preauthorizations.
  - Only Show Preauths: Only show preauthorizations.
- **Ignore Custom Tracking:** Do not consider or show claim tracking status in report results (Edit Claim - Status History Tab). If ignored, the days suppressed values as a result of the status will be ignored. If custom tracking status does show in the report (this box unchecked), the report will print in landscape mode.
- **Treat Provs:** Filter the report by treating provider. Click the dropdown, then highlight the providers to include. Press Ctrl while clicking to select multiple providers.
- **Clinics:** Filter by clinic. Click the dropdown, then highlight the clinics to include. Press Ctrl while clicking to select multiple clinics.
- **For User:** Only list outstanding claims assigned to a specific user for follow-up. Use the dropdown, click [...] to select from a pick list (Select All = All Users. Select None = Unassigned.), or click Mine to only view outstanding claims assigned to the logged-on user.
- **Last Claim Custom Tracking Status:** Filter by last recorded claim tracking status. Click the dropdown to select an option. Custom track statuses are attached to claims in the Edit Claim Window, Status Tab.
- **Carrier:** Filter by insurance carrier. Enter the carrier name.
- **Last Error Definition:** Filter by claim error code. Error codes are attached to claims in the Edit Claim window, Status Tab.

Claims: The columns below can show in the grid. Customize which columns show in Display Fields, Outstanding Ins Report.

- **Carrier Name:** The insurance carrier.
- **Phone:** The insurance carrier’s phone number.
- **Type:** The type of insurance (primary, secondary, etc).
- **User:** The user assigned to follow-up on the claim.
- **Patient Name:** To show patient numbers with names, in Report Setup: Misc Settings(1096), select the Show PatNum: Aging, OutstandingIns, ProcsNotBilled option.
- **Clinic:** The clinic on the claim.
- **Date Sent / Orig Sent:** If label is Date Sent, the date the claim was last sent shows. If Orig Sent, the date the claim was originally sent shows.
- **Track Stat:** The last claim tracking status entered. This column won't show if Ignore Custom Tracking is checked.
- **Date Stat:** The date the track status was entered. This column won't show if Ignore Custom Tracking is checked.
- **Error:** The Claim Error code, if one exists. This column won't show if Ignore Custom Tracking is checked.
- **Amount:** The total fee billed to each carrier. This is not the amount that will be paid, so do not use it to determine outstanding insurance payment amounts.
- **GroupNum:** Group number for the subscriber.
- **GroupName:** Group name for the subscriber.
- **SubName:** Subscriber name.
- **SubDOB:** Subscriber date of birth.
- **SubID:** Subscriber ID.
- **PatDOB:** The date of birth of the patient on the outstanding claim.

**Assign Claims to Users**

This tool is useful for delegating responsibility for outstanding claims to specific staff members.

1. Highlight the claim(s) to assign.
2. To assign to the logged on user: Right click, then select Assign to Me.
   To assign to any user: Right click, select Assign to User, then select the user. Or, click Assign User, select the user from the Pick User window, then click OK.

To remove a claim assignment, right click and select another user or open the Assign User window and click Select None.

**View Carrier/Plan and Patient/Subscriber Info**
Click a row in the Claims grid to view information for the selected row.

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<th>Patient/Subscriber Info</th>
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</thead>
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</tr>
<tr>
<td>Carrier Phone: (800)555-4321</td>
<td></td>
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<tr>
<td>Group Number: 000123456</td>
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<td>Group Name: T1025985</td>
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<td>Subscriber Name: Medai, Misty</td>
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<tr>
<td>Subscriber ID: 3245</td>
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</table>

**Update Claim Tracking Status**
Use this tool to change the Track Status and/or Error Code of all claims currently in the grid. The tool is only enabled for users who have the *Update Custom Tracking* security permission.
1. Change report filter criteria as needed.
2. Click Update Custom Tracking.

3. Click the dropdown to select a status.
4. Add a note if desired.
5. Click Update. The Track Status, Error Code and Date Status for all claims will update.

**Print the Report**
To print the report directly to the printer, click Print.

**Export the Report**
To export the report as a txt or xls file:
1. Click Export.
2. Select the location to save the file, and the file type. The default is the OpenDentalExports folder as set in Data Path Setup.
3. Click Save.
Procedures Not Billed to Insurance Report

In Standard Reports(1278), in the Monthly section, click Procedures Not Billed to Ins.

This Standard Report generates a list of procedures with an outstanding insurance estimate that haven't been attached to a claim. All procedures on this list should either be billed to insurance or marked Do Not Bill to Ins in the Procedure Info window(303). You can also create batch claims for unbilled procedures from here (see Procedures Not Billed to Insurance - New Claims(493)).

- Note: To control user access to this report, see Report Setup: Security Permissions(1092).
- To include patient numbers with the names in the report, in Report Setup: Misc Settings(1096) select Show PatNum: Aging, OutstandingIns, ProcsNotBilled.

Select the report criteria, then click Refresh to update the list. Right-click a patient to go to their account (the report can remain open while working in other windows).

- From / To Dates: Today's date is the default. To change, click a down arrow, then select the report start date in the first calendar and the end date in the second calendar. To close the calendars, click an up arrow again or Refresh.
- Show Procedures Completed Before Insurance Added: By default the report only includes procedures that were completed while the patient had insurance coverage. Check this box to include procedures that were completed before the patient's insurance was added.
- Clinics: Highlight the clinics to include. Click All to select all clinics or press Ctrl while clicking to select multiple.
- Include Medical Procedures: By default the report only includes procedures for patients who have dental insurance plans. To also include procedures for patients who have medical insurance, check this box.

Note: Use the Automatically Group Procedures checkbox when creating claims from this window. If checked, and procedures for a patient have different clinics or place of service, claims for each clinic/place of service will be created. If unchecked, you will be blocked from creating claims when patient procedures have different clinic/place of service.

New Claims: Click to create a new claim for the highlighted procedures. User must have Procedures Not Billed to Insurance, New Claims button permission.

Click Print to print the report. For a description of toolbar buttons, see Complex Report System(1280).
Columns show patient name, procedure status, procedure date, procedure description, and the procedure fee.

Click Close to close the report window.

**Troubleshooting**
If you receive the message "No claims can be created because all procedure dates extend past the lock date for this report", it is because of the lock date/days set in the Security Permission Procedures Not Billed to Insurance, New Claims Button is preventing the claims from being made after a certain time frame. This value can be adjusted or removed through Group Permissions(1115)

**PPO Writeoffs Report**
In Standard Reports(1278), in the Monthly section, click PPO Write-offs.
Use the PPO Write-offs report to compare write-offs by claim or carrier. The report will list standard fees, PPO fees, and write-off amounts.

- Note: To control user access to this report, see Report Setup: Security Permissions (1092).
- Write-offs are only tracked for insurance plans that use the PPO Percentage plan type. PPO Insurance Plan (114)
- The provider on the report is the Billing Provider on the claim.

Calendar: In the first calendar select the start date. In the second calendar select the end date. The date range defaults to last month.

Individual Claims/Group by Carrier: Select the sort order of the report.
- Individual Claims: List fees and write-offs by claim.
- Group by Carrier: List total fees and write-offs by carrier. To further limit results, enter carrier name.

Show Insurance Write-offs: Determines the date write-offs are applied. See Show Insurance Writeoffs (1290) for more details.
- Using insurance payment date: Apply write-offs on the date the insurance claim is received.
- Using procedure date: Apply write-offs on the day the procedure is completed.
- Using initial claim date for write-off estimates, insurance pay date for write-off adjustments.

Example of a PPO Write-off Report by Individual Claim
Example of a PPO Write-off Report by Carrier

For a description of toolbar buttons, see Complex Report System(1280).

Payment Plans Report
In Standard Reports(1278), in the Monthly section, click Payment Plans.
This report lists guarantors who owe money on Patient Payment Plans (239) and the total amounts owed. It is often used with the Aging of Accounts Receivable (A/R) Report (1308) to determine which patients owe the office money.

Note: To control user access to this report, see Report Setup: Security Permissions (1092).

**Date Range:** To limit the report to plans created in a date range:
- Check the Limit to Plans Created in a Date Range box. This is the default selection and enables the Date Start and Date End fields.
- In the Date Start field, click the dropdown to select the start date.
- In the Date End field, click the dropdown to select the end date.
If you uncheck the **Limit to Plans Created in Date Range** box, the report will show all plans, regardless of date.

**Payment Plan Types:** Select which types of payment plans to include:
- Insurance (payment plans that have the Track expected insurance payments checkbox selected)
- Patient
- Both

**Hide Completed Payment Plans:** Check this box to exclude closed payment plans from the report.
- Note: In version 16.1 and earlier, plans were considered completed when the balance was zero and there were no future charges. In 16.2 and greater, a plan has to be closed to be considered complete.

**Show Family Balance:** Check this box to show each guarantor's total family balance.

**Providers:** Highlight the providers to include. Click All to select all providers.

**Clinics:** Select the clinics to include. Click All to select all clinics. The report will be grouped by clinic.

For a description of toolbar buttons, see Complex Report System (1280).
**Columns**

- **Provider**: The provider attached to the plan.
- **Guarantor**: The guarantor of the plan.
- **Ins**: Indicates insurance payment plans.
- **Princ**: The total principal amount.
- **Accum Int**: Accumulated interest for the plan.
- **Paid**: The total amount paid on the plan.
- **Balance**: The current payment plan balance (Princ + Accum Int - Paid).
- **Due Now**: The amount that is due now.
- **Balance Not Due**: The total payment plan balance that is not yet due (is due in the future). (Balance - Due Now). Only shows when the pay plan logic is Age Credits and Debits.
- **Fam Balance**: The total family balance.

### Receivables Breakdown Report

In [Standard Reports](1278), click **Receivables Breakdown**.
This report is a breakdown, by date, of outstanding patient balances.

**Production**: Total amount of completed procedures.

**PayPlanCredit**: Credits applied to patient accounts to offset payment plan charges. See [Payment Plan Procedures and Credits](#).

**Prod-PPCred**: Production after PayPlanCredits are subtracted.

**PayPlanCharges**: Payment plan debits.

**Adjustments**: Total combined positive and negative Adjustments(203).

**Writeoff**: PPO and capitation insurance write-offs.

**Payment**: Amount received from patient payments.

**InsPayment**: Amount received from insurance payments.

**Daily A/R**: Net change in account receivables.

**Ending A/R**: Total account receivables.

- Note: If the [Account Module Preferences](#) Pay Plan Logic is set to *Aged Credits and Debits*, this report will take into account payment plan amounts due. Otherwise it will not.
- To make the totals on this report match the Aging of A/R report total, see the bottom of this page.
- To control user access to this report, see [Report Setup: Security Permissions](#).  

To generate this report:

1. In the main menu, click Reports, Standard.
2. In the Monthly section, click Receivable Breakdown.
3. **Providers**: Select the treating providers to include. Practice is the default option and the same as including all providers. Provider selection is only an option if the logged-on user has the *Production and Income, View All Providers* permission.

4. **Show Insurance Write-offs**: Select when write-offs should be applied. See [Show Insurance Writeoffs](#) (1290) for more details.
   - Use insurance payment date: Apply write-offs on the date the insurance claim is received.
   - Use procedure date: Apply write-offs on the day the procedure is completed.

5. **Up to the following date**: Select the end date for the report. The start date is always the first day of the month.

6. Click OK to generate the report.

### Matching Receivables Breakdown and Aging of A/R Totals

To get the [Aging of Accounts Receivable (A/R) Report](#) (1308) Total to match the Receivables Breakdown, Ending A/R Total, run each report for all providers and select the options below.

**Note**: Reports will not match if you have payment plans.

**Receivables Breakdown Report**:
- Provider: Practice
- Show Insurance Write-offs: Select Using insurance payment date.
- Dates: Same as Aging of A/R Report.

**Aging of A/R Report**:
- Date: Same as Receivables Breakdown report.
- Age of Account: Any Balance
- Negative Balances: Check Include negative balances. - Do NOT check Only show negative balances.
- Exclusions: Do NOT check any of the exclusions.
- Billing Types: All
- Providers: All

The reports will not match if run for specific providers, even if there are no payment plans. The Aging of A/R report includes all entries associated with any patient who has the selected provider as their primary provider at the time of the work. The Receivable Breakdown includes ONLY the entries where the selected provider was the provider on the procedure/claim/adjustment/write-off. These totals will be very different.
Unearned Income Reports

In Standard Reports (1278), in the Monthly area, click Unearned Income.

There are four types of Unearned Income (191) Reports.

- Unearned Allocation Report (1326)
- Net Unearned Income Report (1328)
- Line Item Unearned Income Report (1329)
- Unearned Accounts Report (1330)

Note: To determine user access to these reports, see Report Setup: Security Permissions (1092). The Unearned Income reports use the Complex Report System (1280).

Unearned Allocation Report

This Unearned Income Report shows all families where one or more patients have unearned income with subsequent completed procedures.

In Unearned Income Reports (1326), click Unearned Allocation.
Patients on this report may need to have their Unearned / Prepayments(191) allocated to the listed procedures.

Note: To determine user access to these reports, see Report Setup: Security Permissions(1092). The Unearned Income reports use the Complex Report System(1280).

Select the Unearned Types to include or check All. Set up additional unearned types in Definitions: PaySplit Unearned Types(880).

(Optional) Uncheck Show provider column to hide the column of providers allocated to each prepayment. When checked if a provider is not allocated to a prepayment, the column is blank.

(Optional) Check Exclude families with a net $0.00 unearned income balance. This will remove families with no current unearned income from the report.

Filter Providers and Clinics or check All. This limits results to guarantor's with a specific primary provider and assigned clinic.

Click OK to generate the report.

**Logic**

This report shows all families where one or more patients have a prepayment paysplit attached to them with subsequent completed procedures that have a remaining patient portion due.
Net Unearned Income Report

This Unearned Income Report shows families with patients that have unearned income payments collected and no unallocated procedures.

In Unearned Income Reports (1326), click the Net Unearned Income tab.

Patients on this report need to have treatment scheduled to allocate the payment or have a refund issued.

Note: To determine user access to these reports, see Report Setup: Security Permissions (1092). The Unearned Income reports use the Complex Report System (1280).

Select the Unearned Types to include or check All. Set up additional unearned types in Definitions: PaySplit Unearned Types (880).

(Optional) Check Exclude families with a net $0.00 unearned income balance.

Filter Providers and Clinics or check All. This limits results to guarantor's with a specific primary provider and assigned clinic.

Click OK to generate the report.
Line Item Unearned Income Report

This Unearned Income Report shows details for unearned income activity in a date range.

In the Unearned Income Reports, click the Line Item Unearned Income tab.

Positive Unearned / Prepayment amounts on this report indicate either a collected prepayment or a patient payment transferred to unearned income, within the selected date range. Negative amounts indicate unearned has been allocated to a charge, has been refunded, or transferred to another source.

Note: To determine user access to these reports, see Report Setup: Security Permissions. The Unearned Income reports use the Complex Report System.
Select a date range using the **From** and **To** calendars. The default date range is the previous month.

(Optional) Uncheck **Show provider column** to hide the column of providers allocated to each prepayment. When checked if a provider is not allocated to a prepayment, the column is blank.

Filter by the **Clinic** allocated to prepayments or check **All**. **Unassigned** includes prepayments not allocated to a clinic.

Click OK to generate the report.

---

**Unearned Accounts Report**

This Unearned Income Report shows the total family unearned income balance by guarantor.

In **Unearned Income Reports** (1326), click **Unearned Accounts**.

This helps identify the remaining **Unearned / Prepayment** (191) balance for a family that can be allocated.
Note: To determine user access to these reports, see Report Setup: Security Permissions (1092). The Unearned Income (191) reports use the Complex Report System (1280).

Filter by the guarantor's assigned Clinic or check All.

Click OK to generate the report.

**Unearned Accounts**

Relaxation Dental
All Clinics

<table>
<thead>
<tr>
<th>Guarantor</th>
<th>Type</th>
<th>Clinic</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evans, Sara</td>
<td>Prepayment</td>
<td>Clinic A</td>
<td>800.00</td>
</tr>
<tr>
<td>Jones, Miranda</td>
<td>Prepayment</td>
<td>Clinic A</td>
<td>500.00</td>
</tr>
<tr>
<td>McMann, Tim</td>
<td>Prepayment</td>
<td>Clinic B</td>
<td>600.00</td>
</tr>
<tr>
<td>Medal, Misty</td>
<td>Credit</td>
<td>Clinic A</td>
<td>200.00</td>
</tr>
<tr>
<td>Miller, Janelle</td>
<td>Overpayment</td>
<td>Clinic A</td>
<td>450.00</td>
</tr>
</tbody>
</table>

2,550.00

**Insurance Overpaid Report**

In Standard Reports (1278), in the Monthly section, click Insurance Overpaid.

The Insurance Overpaid Report finds situations where the insurance payment, plus any write-off, exceeds the fee.

Note: To control user access to this report, see Report Setup: Security Permissions (1092).

**Clinics:** Highlight the clinics to include. Click All to select all clinics.
**Group by procedure (default):** Select this option to group the report by procedure.

**Group by patient and date:** Select this option to group the report by patient and date.

For a description of toolbar buttons, see [Complex Report System](1280).

To handle the items on this list, find the original EOBs and verify.

Fixing Old Payment Amounts: It is unlikely that an entry error of the payment amount would have been the cause, because the daily deposit slip would not have balanced and the bank would have rejected the deposit. It is difficult to fix this kind of entry error. It will involve deleting the old deposit slip and the old insurance payment (not the claim procedure or the claim). Then, after fixing the payment amount, the insurance check and deposit would be recreated.

Fixing Old Write-offs: Someone with the appropriate permissions can directly edit the erroneous writeoff amounts. Beware that this will alter historical reports.

Sending a Refund: If insurance truly did overpay, they must be notified so that a refund can be arranged. Open the claim, highlight the involved procedures, and click the Supplemental button at the upper right. Enter negative payment amounts. Create an insurance payment with a negative amount. This properly fixes the patient account and makes the patient responsible for the previous overpayment. If the overpayment was discovered after an unreasonable amount of time, the office has the option of entering a patient adjustment to not make the patient responsible.

**Presented Treatment Production Report**

In [Standard Reports](1278), in the *Monthly* section, click **Presented TreatPlan Production**.
This report totals the production from completed procedures that are attached to saved Treatment Plans (283). It can produce a detailed report by procedure or total production amounts by treatment plan user or presenter.

**Note:** To control user access to this report, see Report Setup: Security Permissions (1092).

**Calendars:** Select the date range for the report. Only production for procedures set complete within the date range will be included. The default is last month.
- In the first calendar select the start date.
- In the second calendar select the end date.

**Report Type:** Select the type of report.
- Detailed: Show production by procedure.
- Total: Show total production for each user or presenter.

**Order Presented:** Production for procedures on multiple treatment plans will only be counted once. Select to whom production for these procedures should be attributed.
- First Presented: Attribute production to the user or presenter on the treatment plan saved first.
- Last Presented: Attribute production to the user or presenter on the treatment plan saved last.

**User Displayed:** Select how the presenter will be determined.
- Presenter: The presenter associated with the treatment plan.
- Entry User: The user entry associated with the treatment plan.
**Users:** Select the users (or presenters) to include. Check All to include everyone, or uncheck All and select individual users.

**Clinics:** Select the clinics to include. Check All to include all clinics, or uncheck All and select individual clinics.

Click OK to generate the report. For a description of toolbar buttons, see [Complex Report System](#)(1280).

Detailed report (production by procedure)

![Detailed report image]

Total report (total production by user or presenter)

![Total report image]
In **Standard Reports** (1278), in the *Monthly* section, click **Treatment Presentation Statistics**.

This report shows various metrics about saved treatment plans, by treatment plan presenter, including:

- Total number of treatment plans saved in a date range.
- Total number of procedures in the saved treatment plans.
- Total number of procedures that currently have a status of scheduled or completed.
- Gross and net totals for presented plans and procedures.

- **Note:** To assign presenters to treatment plans, see [Edit Treatment Plan](286).
- To control user access to this report, see [Report Setup: Security Permissions](1092).

**Calendars:** Select the date range for the report. Only treatment plans saved within the date range will be included. The default is last month.

- In the first calendar select the start date.
- In the second calendar select the end date.

**Calculated Production:**
- Gross Production: Calculates gross production only.
- Net Production: Calculates net production (gross production - estimated or actual write-offs - discounts - adjustments).

**Order Presented:** Production for procedures on multiple treatment plans will only be counted once. Select to whom production for these procedures should be attributed.
- First Presented: Attribute production to the user or presenter on the treatment plan saved first.
- Last Presented: Attribute production to the user or presenter on the treatment plan saved last.

**User Displayed:** Select how the presenter will be determined.
- Presenter: The presenter associated with the treatment plan.
- Entry User: The user entry associated with the treatment plan.

**Users:** Select the users (or presenters) to include. Check All to include everyone, or uncheck All and select individual users.

**Clinics:** Select the clinics to include. Check All to include all clinics, or uncheck All and select individual clinics.

Click OK to generate the report. For a description of toolbar buttons, see Complex Report System(1280).

**Gross Production Example**

![Gross Production Example](image)

**Net Production Example**
**Presenter:** The treatment plan presenter.

**# of Plans:** The number of treatment plans saved in the date range.

**# of Procs:** The total number of treatment planned procedures in saved treatment plans. Excludes deleted procedures that are still listed in a saved treatment plan.

**# of ProcsSched:** The total number of treatment planned procedures in saved treatment plans that are attached to an appointment with a status of *scheduled* and were created in the date range.

**# of ProcsComp:** The total number of procedures completed from saved treatment plans that were created in the date range.

**GrossTPAmt:** The total gross amount for all treatment planned procedures in saved treatment plans created in the date range. Excludes deleted procedures that are still listed in a saved treatment plan.

**GrossSchedAmt:** The total gross amount for all treatment planned procedures in saved treatment plans created in the date range, that are attached to an appointment with a status of *scheduled*.

**GrossCompAmt:** The total gross amount for all completed procedures in saved treatment plans created in the date range.

**NetTPAmt:** The total net amount for all treatment planned procedures in saved treatment plans created in the date range. Excludes deleted procedures that are still listed in a saved treatment plan.

**NetSchedAmt:** The total net amount for all treatment planned procedures in saved treatment plans created in the date range, that are attached to an appointment with a status of *scheduled*.

**NetCompAmt:** The total net amount for all completed procedures in saved treatment plans created in the date range.

---

**Insurance Payment Plans Past Due Report**

In [Standard Reports](1278), in the *Monthly* section, click [Ins Pay Plans Past Due](#).
The Insurance Payment Plans Past Due Report lists patients with Insurance Payment Plans (258) that have balances overdue by at least 30 days. This report is especially useful for orthodontic offices. Insurance payment plan past due amounts do not show in the patient's payment plans grid.

Note: To control user access to this report, see Report Setup: Security Permissions (1092).

Patients with insurance plans past due that meet the criteria will list. Click a column title to sort results in ascending or descending order.

Change the report criteria:
- **Days past due**: Filter report by number of days the insurance payment plan is past due. 30 days is the default. Enter any number above 30 to further refine the search results.
- **Provs**: Select providers to include, or select All providers.
- **Clinics**: Select the clinics to include in the report, or select All clinics.

Click Print to print the report grid, or Export to save it as a .txt file.

Columns:
- **Patient**: Name of the patient with an outstanding insurance payment plan.
- **DateLastPmt**: The date of the last received insurance plan payment.
- **#Overdue**: Number of insurance plan payments that are overdue.
- **AmtOverdue**: Dollar amount of the payment that is overdue.
- **CarrierName/Phone**: Name and phone number of the insurance company attached to the overdue payment plan.

**Insurance Aging Report**

In **Standard Reports** (1278), in the **Monthly** section, click **Insurance Aging Report**.
This Standard Report ages the Insurance Estimates of families with outstanding balances. It is based on the guarantor's billing type, primary provider, and clinic. Aging is automatically recalculated when the report is generated.

- Note: To control user access to reports, see Report Setup: Security Permissions.
- To set other report defaults, see Report Setup: Misc Settings (text wrapping, include patient number).
- The aging of negative adjustments is determined by the Account Module Preferences, Age negative adjustments by adjustment date.

**As of Date:** Enter the as of date for the report. Defaults to the date of the most recent aging calculation (usually today). If changed to an historical date, totals reflect all transactions up to the date entered except for estimated write-offs.

**Age of Account:** Select which patients to include based on aging balance.
- Any Balance: Include patients with any balance due.
- Over 30 Days: Include all patients with any balances that are over 30 days due.
- Over 60 Days: Include all patients with any balances that are over 60 days due.
- Over 90 Days: Include all patients with any balances that are over 90 days due.

**Group By:** Select how to group calculation amounts.
- Family (default): Group by family, listed by guarantor.
- Individual: Group by individual patient.

**Only show patients with outstanding claims:** Check to limit report to patients with outstanding claims, and enable insurance breakdown options below. Results will be grouped by both carrier name and group name.

**Insurance Breakdown Options:** Only shows when Only show patients with outstanding claims is checked.
- Filter:
1340

- **Carrier Name like**: Filter report using Carrier Name.
- **Group Name like**: Filter report using Group Name.

**Billing Types**: Highlight the billing types to include or click All to include all billing types.

**Providers**: Highlight the primary providers to include or click All to include all primary providers.

**Clinics**: Highlight the clinics to include or click All to include all clinics. Only clinics the logged-on user has access to are options.

*Note*: When the report is grouped by family, clinic is determined by the guarantor's assigned clinic. When grouped by individual, clinic is determined by the patient's assigned clinic.

Click **OK** to generate the report.

**Report without Detailed Insurance Breakdown:**

![Insurance Aging Report]

**Report with Detailed Insurance Breakdown**: Detailed breakdown will first Group by Family or Individual, and then group by Carrier and/or Group Name as selected in report options.
Column descriptions: Below is a description of each column in the report. The columns will vary depending on the report criteria.

- **Guarantors**: The patients/guarantors who meet the filter criteria.
- **Ins Pay 0-30 Days**: The estimated insurance balance that is 30 days past due.
- **Ins Pay 31-60 Days**: The estimated insurance balance that is 31-60 days past due.
- **Ins Pay 61-90 Days**: The estimated insurance balance that is 61-90 days past due.
- **Ins Pay <90 Days**: The estimated insurance balance that is greater than 90 days past due.
- **Ins Est Total**: The total amount owed by insurance.
- **Pat Est 0-30 Days**: The patient estimated balance that is 30 days past due.
- **Pat Est 31-60 Days**: The patient estimated balance that is 31-60 days past due.
- **Pat Est 61-90 Days**: The patient estimated balance that is 61-90 days past due.
- **Pat Est <90 Days**: The patient estimated balance that is greater than 90 days past due.
- **W/O Change**: The difference between the original write-off estimate and the current write-off estimate (if changed) for unreceived claims.
- **Pat Total**: The total amount estimated to be owed by patient.

**Custom Aging Report**

In **Standard Reports** (1278), in the **Monthly** area, click **Custom Aging**.
The Custom Aging report allows users to customize which transactions to age. The default criteria settings match the Aging of Accounts Receivable (A/R) Report (1308). Aging can be run as of a historical date (see As Of Date).

Note: To control user access to this report, see Report Setup: Security Permissions (1092).
This report is available by default to users with the Aging of AR permission.
The Pay Plan defaults depend on settings found in Account Module Preferences (693), Pay Plan Logic section.

Select filter criteria and click Refresh to generate the report. Click a column heading to sort.
Click Print to print results as shown in the grid.

**Customize the Report**

As Of Date: Enter a date from which to begin calculating aging. Default is today.

Include the following: Check a criteria box to include it in the aging report.
- **Procedure Fees:** Include procedure fees.
- **Adjustments:** Include adjustments.
- **Pay Plan Charges:** Include pay plan charges in the aged amounts.
- **Pay Plan Credits:** Include pay plan credits in the aged amounts. See Payment Plan Procedures and Credits (256).
- **Patient Payments:** Include patient payments.
- **Insurance Payments:** Include insurance payments.
- **Insurance Estimates:** Include insurance estimates.
- **Write-offs:** Include write-offs. Must be checked to show Capitation write-offs.
- **Write-off Estimates:** Include write-off estimates.
Negative Balances
- **Exclude**: Check this box to exclude negative balances.
- **Include**: Check this box to include negative balances.
- **Show Only**: Check this box to only show negative balances.

**Age of Account**: Only show accounts aged over the selected value.

**Age Write-offs by**: Calculate write-offs by insurance payment date, procedure date or using the initial claim date for estimates and insurance pay date for adjustment. The default is determined by the Default to using Proc Date for PPO write-offs preferences in Reports Setup(1090).

**Group By**: Show one patient or family (guarantor) per row.

**Billing Types, Providers, Clinics**: Check All to include all criteria, or select individual items to include.

**Age Credits**: Age credits in increments of 0-30, 31-60, 61-90, and 90+ instead of aging credits using standard calculation (applying credits to oldest charges first).

**Exclude Inactive Patients**: Check to exclude all patients with an inactive status.

**Exclude Archived Patients**: Check to exclude all patients with an archived status.

**Exclude Bad Addresses**: Check to exclude patients with no zip code.

---

**Procedures Overpaid Report**

In Standard Reports(1278), in the Monthly section, click Procedures Overpaid.

The Procedures Overpaid report lists individual procedures that have been overpaid by insurance, the patient, a write-off, or an adjustment.

Payments, write-offs, and adjustments must be allocated to procedures in order for this report to pull data correctly.

**Note**: To control user access to this report, see Report Setup: Security Permissions(1092).

**From / To**: Enter the date range the procedure was set complete.

**Providers**: Select the providers attached to the procedure.

**Clinics**: If using clinics, select which clinic to filter by.

**Patient**: By default, will enter the patient that is currently selected.
- **Current**: Enters the patient currently selected.
• **Find**: Find and enter a specific patient.
• **All**: Filter report for all patients with overpaid procedures.

Click **Refresh** for filters to take affect.

Click **Print** to print the grid.

---

**Monthly Production Goal Report**

In **Standard Reports** (1278), in the Production and Income section, click **Monthly Production Goal**.

The Monthly Production Goal report compares your production goals with your actual production. Production goals can be set from the **Edit Provider** (1255) window.

**Providers**: Select the providers needed on the report, or check **All**.

**Clinics**: Select the clinics needed on the report, or check **All**.

**Date Range**: Select the date range criteria.
• **This Month**: Click to run the report for the current month.
• **From / To**: Enter specific to and from dates to run the report for.

**Show Insurance Write-offs**:
• **Using insurance payment date**: Write-offs are calculated based on date of insurance payment.
• **Using procedure date**: Write-offs are calculated based on date of procedure.
• **Using initial claim date for write-off estimates, ins pay date for write-off adjustments**.

Click **OK** to generate the report.
Active Patients Report
The Active Patient report lists all active patients that have had a completed procedure within a specific date range.

In Standard Reports (1278), in the Lists section, click Active Patients.
Patients with any status other than Patient will not show on this report. Active patient reports can be filtered by clinic, provider, and billing type.

- **Note:** To control user access to this report, see [Report Setup: Security Permissions](1092).
- To print a list of inactive patients, try [Query Examples](285) 285 or 49.

Choose report criteria:
- **Calendar:** Choose a date range. The left calendar shows the start date; the right calendar shows the end date. Calendar automatically defaults to Today's date.
- **Billing Types:** Check All to include all billing types or uncheck the box and select specific types.
- **Providers:** Check All to include all providers or uncheck the box and select specific providers. Uses the patient's primary provider.
- **Clinics:** If using Clinics, check All to include all clinics or uncheck the box and select specific clinics.

Click OK to preview the report.
This list can be printed, or exported as a .txt file. This list is sorted first by clinic, then by provider, and then by last name. For a description of toolbar buttons, see Complex Report System (1280).

### Appointments Report

In Standard Reports (1278), in the Lists section, click Appointments.
The Appointments report is a list of all appointments for a date or date range, and for all or specific providers or clinics. It can also be used to track which appointments made using Web Sched Recall, Web Sched New Patient, or Web Sched ASAP (see Web Sched Feature).

- **Note**: To control user access to this report, see Report Setup: Security Permissions (1092).
- Another option for Web Sched appointments is the Web Sched Appointments Report (1371).

1. **Providers**: Highlight the providers to include. Press Ctrl while clicking to select multiple providers, or click All to select all providers.
2. **Clinics**: If using Clinics highlight the clinics to include. Press Ctrl while clicking to select multiple clinics or click All to select all clinics.
3. **Date Range**: Enter the start and end date, or click Today or Tomorrow to change both dates to today or tomorrow's date.
   - **Appointment Date**: Orders report by the date of the appointment.
   - **Appointment Date Created**: Orders report by date the appointment was created.
   - **Show “Note” Appointments**: Includes notes for patients that have been created from the View Pat Appts window.
4. **Web Sched Appointments Only**: If using Web Sched, track which appointments were scheduled using each service by filtering the report. Selecting one or both of these options will result in only appointments that meet the criteria to be included in the report. All other appointments will be excluded.
   - **Show Recall Appointments**: Show appointments scheduled using Web Sched Recall.
   - **Show New Patient Appointments**: Show appointments scheduled using Web Sched New Patient.
   - **Show ASAP Appointments**: Show appointments scheduled using Web Sched ASAP.
5. Click OK to preview the report.
For a description of toolbar buttons, see Complex Report System(1280).

Birthday Report and Postcards

In Standard Reports(1278), in the Lists section, click Birthdays.

The Birthdays report is a list of all patients who have birthdays within a specific date range. You can also print postcards for each patient with a personalized message. There is also a birthday section in Laser Labels(1277) which prints sheets of labels.

Note: To control user access to this report, see Report Setup: Security Permissions(1092).

1. **Date Range**: Select the from and to dates to include in the report. Click the arrows to move forward/back one month at a time, or click Next Month.
2. **Message**: Personalize the postcard message. Three unique keywords can be used. These will be replaced with patient information on the postcard.
   - FName: patient's first name.
   - AgeOrdinal: patient's ordinal age, e.g. 44th, 22nd.
   - Age: patient's age, e.g. 44, 22.

Click Save Msg to save the message for later use.

3. To print postcards, click Preview to first generate the postcards. Then click Print on the preview window.
   
   **Note**: We recommend FormSource as a printing vendor. See their Open Dental Health Care Form Price List.

---

**Happy Valley Office**
5216 S Welcome Way
Happy Valley, OR 97081
(351)888-3514

---

Dear Lucy, Happy 44th Birthday!
Now you are 44 years old.

Lucy Johnson
321 Illaha
Salem, OR 97305

---

To generate a list of names, addresses, birth dates, and ages for patients with birth dates within the set date range, click **Report**.

---

**Birthdays**
Relaxation Dental
08/01/2018 - 09/30/2018

<table>
<thead>
<tr>
<th>FName</th>
<th>LName</th>
<th>Preferred</th>
<th>Address</th>
<th>Address2</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
<th>Birthdate</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outstanding</td>
<td>Emma</td>
<td></td>
<td>485 Etna St</td>
<td></td>
<td>Salem</td>
<td>OR</td>
<td>97301</td>
<td>08/04/1984</td>
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<tr>
<td>Snow</td>
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<td></td>
<td>123 6th st</td>
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<td>7575 Elder St</td>
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<td>Oceana</td>
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<td>6267 Water W</td>
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<td>Keizer</td>
<td>OR</td>
<td>97218</td>
<td>08/12/1980</td>
<td>38</td>
</tr>
<tr>
<td>Halpert</td>
<td>Pam</td>
<td></td>
<td>487 Maple St</td>
<td></td>
<td>Scranton</td>
<td>PA</td>
<td>08/19/1982</td>
<td>35</td>
<td></td>
</tr>
<tr>
<td>Moore</td>
<td>Harrison</td>
<td></td>
<td>6054 Galactic</td>
<td></td>
<td>Keizer</td>
<td>OR</td>
<td>97210</td>
<td>08/21/1970</td>
<td>40</td>
</tr>
<tr>
<td>Jones</td>
<td>Milo</td>
<td></td>
<td>123 Happy st</td>
<td></td>
<td>Salem</td>
<td>OR</td>
<td>97301</td>
<td>08/25/2014</td>
<td>4</td>
</tr>
<tr>
<td>Dwyer</td>
<td>April</td>
<td></td>
<td>123 A St</td>
<td></td>
<td>Pammee</td>
<td>IN</td>
<td>13467</td>
<td>09/12/1993</td>
<td>25</td>
</tr>
<tr>
<td>Gasperetti</td>
<td>Lizzie</td>
<td>Liz</td>
<td>3446 Hanes St</td>
<td></td>
<td>Salem</td>
<td>OR</td>
<td>97301</td>
<td>09/23/2017</td>
<td>1</td>
</tr>
</tbody>
</table>

This list can be printed or exported as a txt file.

For a description of toolbar buttons, see Complex Report System(1280).

To edit the number of post cards that print on each sheet, see Setup Recall(632).

---

**Broken Appointments Report**
In Standard Reports(1278), in the Lists area, click Broken Appointments.
The Broken Appointment report lists patients who have a broken appointment during a date range and any associated fees charged. It is grouped by clinic. Also see Break Appointment(55).

Note: To control user access to this report, see Report Setup: Security Permissions(1092).

**Calendar:** Select the date range. Select the start date in the first calendar and the end date in the second calendar.

**Providers:** Highlight the providers to include. Press Ctrl while clicking to select multiple providers, or click All to select all providers.

**Clinics:** Select the clinics to include. Press Ctrl while clicking to select multiple clinics, or click All to select all clinics.

Select which patients will be included based on the different methods of marking broken appointments. There are three options:
- **By procedures:** Include patients who have a D9986 or D9987 completed procedure.
- **By adjustments:** Include patients with a specific adjustment type. Select the adjustment type in the list box on the right.
- **By appointment status:** Include patients who have appointments with a status of broken.

The default setting for this option is based on the Broken Appointment Automation option selected in Appointment Module Preferences. See Technical Details at the bottom of this page.

Click OK to generate the report.

Broken appointment report by procedure.
Broken appointment report by adjustment type.

<table>
<thead>
<tr>
<th>Date</th>
<th>Provider</th>
<th>Code</th>
<th>Patient</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>07/21/2017</td>
<td>Sparks</td>
<td>D9987</td>
<td>Anderson, Alexa</td>
<td>0.00</td>
</tr>
<tr>
<td>07/21/2017</td>
<td>Sparks</td>
<td>D9987</td>
<td>Andrews, Milly</td>
<td>0.00</td>
</tr>
<tr>
<td>07/21/2017</td>
<td>Sparks</td>
<td>D9987</td>
<td>Appleton, Mary</td>
<td>0.00</td>
</tr>
<tr>
<td>07/21/2017</td>
<td>Sparks</td>
<td>D9986</td>
<td>Appleton, Mary</td>
<td>0.00</td>
</tr>
<tr>
<td>07/21/2017</td>
<td>Sparks</td>
<td>D9986</td>
<td>Appleton, Mary</td>
<td>0.00</td>
</tr>
<tr>
<td>07/28/2017</td>
<td>Sparks</td>
<td>D9986</td>
<td>Gray, Garrison</td>
<td>0.00</td>
</tr>
</tbody>
</table>

Total Broken Appointment Fees: $0.00
Total Broken Appointments: 6
Broken appointment report by appointment status.

**Broken Appointments**
By Appointment Status
All Providers
All Clinics

Date: 10/03/2017

<table>
<thead>
<tr>
<th>AptDate</th>
<th>Patient</th>
<th>Doctor</th>
<th>Hygienist</th>
<th>IsHyg</th>
</tr>
</thead>
<tbody>
<tr>
<td>07/04/2017</td>
<td>Burnaby, Jack</td>
<td>Sparks</td>
<td></td>
<td></td>
</tr>
<tr>
<td>07/28/2017</td>
<td>Harrison, Julie</td>
<td>ENDO</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total Broken Appointments: 2
For a description of toolbar buttons, see Complex Report System (1280).

**Technical Details**
In the Broken Appointments Report, the default selection for which patients are included is determined by the broken appointment automation choice.

1. If a procedure is added to the patient’s chart, the default is always *By procedures*.
2. If procedure’s are not added to the patient’s chart, but commlogs are added, the default is *By appointment status*.
3. If only adjustments are added (not procedures or commlogs), the default is *By adjustments*.
4. If no procedures, commlogs, or adjustments are added, the default is *By appointment status*.

---

**Discount Plans Report**

In Standard Reports (1278), in the *Lists* section, click **Discount Plans**.

This report is a list of all Discount Plans (1230), the associated fee schedule, adjustment type, and patients using the plan.

Note: To control user access to this report, see Report Setup: Security Permissions (1092).

To filter the report to a specific plan, enter it in the box. To include all plans leave blank.

Click OK to generate the report. For a description of toolbar buttons, see Complex Report System (1280).
Hidden Payment Splits Report

Use the Hidden Payment Splits Report to track accounts with prepayment types marked as *Do Not Show on Account*.

In *Standard Reports* (1278), in the *Lists* section, click *Hidden Payment Splits*.

**From / To Dates**: Enter the date range in which to run the report. Use the arrows to quickly move forward or backward by a week.

**Providers**: Select the providers to include on the report, or select All to include all providers.
Unearned Types: Select the Unearned Types to include on the report, or select All to include all Unearned Types.

Clinics: Select the clinics to include on the report, or select All to include all clinics.

Click OK to run the report. All patients with treatment planned procedure prepayments are displayed. The negative values represent the prepayment transferred to the completed procedure.

Insurance Plans Report

In Reports, Standard Reports (1278), in the Lists section, click Insurance Plans.

This report is a list of all insurance carriers and subscribers.

Note: To control user access to this report, see Report Setup: Security Permissions (1092).
To filter the report to a specific carrier, enter it in the box. To include all carriers leave blank.

Click OK to generate the report.

**New Patients Report**

In **Standard Reports** (1278), in the **Lists** section, click **New Patients**.

![New Patients Report](image)

This report lists all new patients whose first completed procedure falls within a specific date range and their total
production. This is not related to the patient's date of first visit. The report can optionally be filtered by primary provider. To report by treating provider instead, see Query by Treating Provider below.

Note: To control user access to this report, see Report Setup: Security Permissions(1092).

**Providers:** Select the providers to include. Select All to include all providers. Press Ctrl and click or click and drag to highlight multiple providers.

**Today's Date:** Automatically populated with today's date.

**Date Range:** The date range determines which patients show based on their first completed procedure. The current month, based on Today's Date, is the default.
- Click the left arrow to move back one month.
- Click the right arrow to move forward one month.
- Click This Month to reset the current month.

Note: The production calculated in the report is for all time, not a specific date or date range.

**Include address information:** Include each patient's preferred name, street address, second address, city, state and zip on the report. If checked, the report will print in landscape mode instead of portrait.

**Exclude patients with no production:** Exclude patients who had no completed procedures or had treatment that resulted in no cost.

Click OK to preview the report. For a description of toolbar buttons, see Complex Report System(1280).

---

**Query by Treating Provider**

To report by treating provider, see Query 1215 in Query Examples. This query will list, by treating provider, all new patients whose first completed procedure date falls within the date range. Since a patient can see more than one provider on their first visit, the sum of the new patient counts may be equal to, or greater than, the standard New Patient Report result. For example, a patient seen by two providers on their initial visit will be counted twice (once for each provider).

---

**Patients Report**

The Patients Report is used to create simple queries using fields in the Patient table.
In **Standard Reports** (1278), in the *Lists* section, click **Patients - Raw**.

Options are hard coded and may not reflect all fields. For more query options, see **Query Examples** or submit a **Query Request**.

**Note:** To control user access to this report, see **Report Setup: Security Permissions** (1092).

To create a query:
1. In the main menu, click Reports, Standard. Under the Lists section, click Patients - Raw.
2. On the **SELECT** tab, select the patient information to show on the report. Items selected will make up the report columns. To include referral information select from the **Referred To/Referred From** lists.
3. Click the **WHERE** tab to create the report rows. Select additional patient information from the WHERE dropdown menu, then select an operator and enter a value in the text box that must be met to limit the report results.

   For example if EstBalance is selected with the operator, less than or equal to, and the value is $100, the report will return all patients with an estimated balance of $100 and less.

4. Click **Add** to create a row and formulate the query. To delete a row, select the row from the list in the center of the page and click **Delete**. It will also be removed from the query statement at the bottom. Add additional WHERE rows as needed.
5. Click **OK** to run the query. The results will open in the **User Query** (1382) window.

To save this query and run again later add to the **Query Favorites** (1385).
Patient Notes Report
In Standard Reports(1278), in the List area, click Patient Notes.

Search all patient note fields for specific text.

Note: To control user access to this report, see Report Setup: Security Permissions(1092).

Enter the characters to search for.

The report will open in the Query window.

Prescriptions Report
In Standard Reports(1278), in the Lists area, click Prescriptions.

Use the prescription report to generate a list of all Rx / Prescription(333), by patient or drug name.
Note: To control user access to this report, see Report Setup: Security Permissions(1092).

Optional. Filter the report by patient or drug name. You only need enter the first few characters, or leave the box blank to include all patients or drugs.

Select how to group the report: by Patient or by Drug name.

Click OK to generate.

### Prescriptions

![Prescriptions Image](image)

**Relaxation Dental**

**By Patient**

<table>
<thead>
<tr>
<th>Date</th>
<th>Patient Name</th>
<th>Drug Name</th>
<th>Directions</th>
<th>Dispense</th>
<th>Prov Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>08/06/2018</td>
<td>Clinic B, Patient</td>
<td>Vicodin</td>
<td>Is Proc required Controlled</td>
<td>10</td>
<td>DOC1</td>
</tr>
<tr>
<td></td>
<td>Clinic B, Patient</td>
<td>Vicodin</td>
<td>Is Proc required Controlled</td>
<td>10</td>
<td>DOC1</td>
</tr>
<tr>
<td></td>
<td>Clinic B, Patient</td>
<td>Vicodin</td>
<td>Is Proc required Controlled</td>
<td>10</td>
<td>DOC1</td>
</tr>
<tr>
<td></td>
<td>Gasperetti, Gary</td>
<td>Vicodin</td>
<td>Is Proc required Controlled</td>
<td>10</td>
<td>DOC1</td>
</tr>
<tr>
<td></td>
<td>Gasperetti, Gary</td>
<td>Vicodin</td>
<td>Is Proc required Controlled</td>
<td>10</td>
<td>DOC1</td>
</tr>
<tr>
<td></td>
<td>Harlper, Pam P</td>
<td>Percocet 5</td>
<td>Take 1 to 2 tablets every 4 to 6 hours for pain</td>
<td>16</td>
<td>DOC1</td>
</tr>
<tr>
<td></td>
<td>Harlper, Pam P</td>
<td>Zovirax 200 mg</td>
<td>Take one tablet five times a day for cold sores.</td>
<td>20</td>
<td>DOC1</td>
</tr>
<tr>
<td></td>
<td>Medical Insurance</td>
<td>Zovirax 200 mg</td>
<td>Take one tablet five times a day for cold sores.</td>
<td>20</td>
<td>DOC1</td>
</tr>
<tr>
<td></td>
<td>Medical Insurance</td>
<td>Zovirax 200 mg</td>
<td>Take one tablet five times a day for cold sores.</td>
<td>20</td>
<td>DOC1</td>
</tr>
<tr>
<td></td>
<td>Moore, Harrison</td>
<td>Zovirax 200 mg</td>
<td>Take one tablet five times a day for cold sores.</td>
<td>20</td>
<td>DOC1</td>
</tr>
<tr>
<td></td>
<td>Rose, Phillip</td>
<td>Vicodin</td>
<td>Is Proc required Controlled</td>
<td>10</td>
<td>DOC1</td>
</tr>
</tbody>
</table>

**Procedure Codes - Fee Schedules Report**

In Standard Reports(1278), in the List section, click **Procedure Codes - Fee Schedules**.
The Procedure Codes - Fee Schedule report prints procedure fees by fee schedule. If you have entered clinic and/or provider-specific fees, you can also print a report of the fees that differ by provider/clinic.

Note: To control user access to this report, see Report Setup: Security Permissions(1092).

Fee schedule: Select the *global* fee schedule to print.

Clinic: Narrow the results to only include fees that are different for the clinic. Select Default to not filter by clinic.

Provider: Narrow the results to only include fees that are different for the provider. Select Default to not filter by provider.

Hint: The options reflect the selection options available when entering fee schedule, clinic, and/or provider fees in the Procedure Code List.

Show blank fees: By default, procedure codes with no fee will not be included in the report. Check this box to include codes with blank fee entries.

Code/Category:
- Code: Sort the report by procedure code.
- Categories: Group the report by procedure code category.

Note: Reports by category never show codes in hidden categories. Reports by code only show codes in hidden categories when they have a fee.

Click OK to preview the report. For a description of toolbar buttons, see Complex Report System(1280).

Below is a report of fees in a global fee schedule, sorted by category.
Below is a report of procedure codes that have clinic fees that are different from the global fees, sorted by code.

Below is a report of procedure codes that have clinic and provider fees that are different from the global fee, sorted by code.

Referral - Raw Report
In Standard Reports (1278), in the Lists section, click Referral - Raw.
This tool helps you write simple SQL queries using fields in the Referral table. Options are hard coded and may not reflect all fields. For more complex queries, see Custom Query Requests.

Note: To control user access to this report, see Report Setup: Security Permissions (1092).

On the SELECT tab, create the SELECT portion of the query. Highlight the columns you want to see. As you highlight items, the statement will show at the bottom.

On the WHERE tab, create the WHERE portion of the query. These options will limit the rows returned to only the criteria you specify.
**Field options:** They may not exactly match the names of the columns.
**Operator:** LIKE, equals, greater than, less than, greater than or equal to, less than or equal to, or not equal to.
**Text Box:** Enter the value that must be met.

Click Add to create the statement. It will show as a row in the middle of the page, and append to the formed query at the bottom.

Add additional WHERE statements as needed. In the formed query, these will be linked by AND. To delete an item, highlight it, then click Delete Row.

Click OK to run the query and view results in the User Query(1382) window.

**Referral Analysis Report**

This report analyzes the incoming referral count and production for a specific date range

In Standard Reports(1278), in the Lists section, click Referral Analysis.
1. In the main menu, click Reports, Standard.
2. In the Lists section, click Referral Analysis.

3. **Providers:** Highlight the providers to include.
4. **Date:** By default a period of the current month based on today's date is selected.
   - Click the right/left arrow to move back/forward one month.
   - Click **This Month** to populate the text boxes with the current month.
   - Or click in each text box to enter custom dates.
5. **Include address information:** Check this box to include address information in the analysis. This is useful if exporting the results for letter merge.
6. **Run as landscape:** Only shows when **Include address information** is checked. This will print the report as landscape.
7. **Only include new patients:** Check this box to only include new patients in the analysis. This is based on the date of the first completed procedure.
8. Click **OK** to generate the analysis.
Below is a description of each column in the report.

- **LastName**: Last name of the referrer.
- **FirstName**: First name of the referrer.
- **Count**: Number of patients referred by each referrer using the selected criteria.
- **Production**: Total gross production from referred patients.

Note: If a patient was referred from more than once source, both sources will list with the full production amount.

### Referred Procedure Tracking Report

In **Standard Reports** (1278), in the **Lists** section, click **Referred Proc Tracking**.
Use the Referred Procedure Tracking report to track pending and completed procedures that have been referred out.

Referrals(76)

Note: To control user access to this report, see Report Setup: Security Permissions(1092).

Referred procedures that meet the default criteria will list. Double click a referred procedure to view and edit.

Date From/To: Enter a report date range. The default is one month.

Show Completed Procedures: Check to include referred out procedures that have a Date Done (Date Proc Completed on Edit Referral Attachment window).

Click Print to print directly to the default printer.
Treatment Finder Report

Use the Treatment Finder report to quickly identify Active patients who have unscheduled treatment planned procedures and remaining insurance benefits.

In Standard Reports (1278), in the Lists section, click Treatment Finder.

Note: To control user access to this report, see Report Setup: Security Permissions (1092).

When first generated, the list includes patients who:
- Have treatment planned procedures (does not include procedures with a $0 fee).
- Have no scheduled appointment.
- Have insurance with a benefit year that follows the calendar year.

Note: By default, the report includes patients whose insurance benefits follow the calendar year (Benefit year = calendar year). It can also be used to identify patients whose insurance benefits start on a specific month (Benefit Year = Month). For these cases, we recommend running the report monthly and simply changing the report criteria. For Ins Month Start, select the starting benefit month to report on. For example, select November to find patients whose benefits expire on November 1st.

Click any column header to sort.
- Contact: Preferred Recall contact method from Edit Patient Information (62). If no Preferred Recall Method is set for a patient the Home Phone Number will display under Contact instead.
- Annual Max: View individual (I) or family (F) annual max insurance benefits. Patients with no annual max will have a Amt Rem of $0.
- Amt Used: View amount of insurance used for completed procedures attached to received, supplemental, or adjustment insurance claims. Individual and family amounts show.
- Amt Pend: View pending insurance claims with attached completed procedures. Individual and family amounts show.
• Amt Remaining: View remaining insurance benefits. Individual and family amounts show. Amount remaining includes completed procedures.
• TreatPlan: Total procedure fees for the individual patient's treatment planned procedures.
• Insurance Carrier: Patient's primary insurance carrier.

Change the report criteria then click Refresh List to update.
• Include patients without insurance: Include patients with no insurance. If checked, the Ins Month Start is ignored.
• Include patients with upcoming appointments: Include patients who have a scheduled appointment in the future. Planned appointments are not included; see Planned Appointment Tracker(39) instead.
• Amount remaining over: Only include patients that have a specific amount of insurance remaining. Results will include patients whose Amt Rem plus Amt Pend is over the amount, and patients who have no annual max.
• TP Date Since: Only include patients who have a dated treatment plan on or after a specified date.
• Ins Month Start: Filter the list by when a patient's insurance year begins. Benefits(86)
  o Calendar Year: Include patients whose insurance plan Benefit year follows the calendar year (ends December 31).
  o Specific Month: Include patients whose insurance plan Benefit year starts on a specific month.
Note: If January is set as a patient's insurance plan's start month, this is not the same as calendar year. To include those patients in the treatment finder report, you must select January as the Ins Month Start.

• Provider: The default option is All which includes all providers (including hidden providers). From the drop down menu select to only include patients with a specific primary provider.
• Billing Type: Include patients with a specific billing type.
• Clinics: Filter results by selected clinic. Users that are restricted to certain clinics will only see those clinics.
• Code Range: Only include patients who have specific treatment planned procedures.
• Assume procedures are General: Assume all procedures for a patient apply towards annual max. Set the default in Report Setup: Misc Settings(1096).

There are three options for viewing a patient:
• To go to a patient's Chart Module(298) quickly, click on the patient row.
• Go to Family: Click to go to a patient's Family Module(59) quickly. You can also right-click on the patient row, then click See Family.
• See Account: Click to go a patient's Account Module(150) quickly. You can also right-click on the patient row, then click See Account.

Letters Preview: Highlight patients you wish to send a letter to. Select the patient letter template to use then click OK. A PDF preview of all letters will generate. Patient letter templates are defined in Sheets(1123)

Export to File: Export all results as a txt or xls file that can be merged or imported into another program. For all patients, Pat Num, Last Name, First Name, Contact Method, Address, City, State, Zip, Annual Max, Amount Used, Amount Pending, Amount Remaining and Treatment Plan total will be exported.

Single labels: Select a patient, then click Single Labels to send the label directly to the printer.

Label Preview: Click to generate a PDF preview of labels. Click Print to send to the printer.

Print List: Click to print the list. See example below:
Note: If using planned appointments, you can also use the Planned Appointment Tracker (39) to track and schedule treatment planned procedures throughout the year.

**Web Sched Appointments Report**

In Standard Reports (1278), click Web Sched Appointments.

Alternatively, from the Web Sched New Patient or Web Sched ASAP alerts click Open eServices Web Sched New Patient Appointment.

Use the Web Sched Appointments report to identify patients who have scheduled appointments using Web Sched New Patient, Web Sched Recall, or Web Sched ASAP (see Web Sched Feature).

Note: To control user access to this report, see Report Setup: Security Permissions (1092).

Appointments that meet the filter criteria will list. Double click an appointment to open it on the Edit Appointment (20).

Note: The report is filtered and sorted by entry date (based on the security log). Thus appointments created, then rescheduled may appear twice.

**Filter Options**

If you change report criteria, click Refresh List to update report results.

**From/To:** Select the date range of appointments to view, based on when the patient created the appointment. Click the down arrow to select days from a calendar; click down arrow again to close the calendar.
Clinics: If using clinics, highlight the clinics to report on. Press Ctrl while clicking to select multiple clinics or click All to select all clinics.

Confirmed Status: Filter the results by Confirmation Status(17).
- Web Sched Recall appointments default to the Not Called confirmed status.

Web Sched Appointment Types: Select the types of Web Sched appointments to report on.
- Show Recall Appointments: Show appointments scheduled using Web Sched Recall.
- Show ASAP Appointments: Show appointments scheduled using Web Sched ASAP.

Raw Screening Data Report
In Standard Reports(1278), in the Public Health area, click Raw Screening Data.

This report is for Public Health(71). It gives you all Public Health Screening data as a single table for a selected date range. Because it is a single table with each patient on one row, you can do extensive statistical analysis. All fields that are required by the standard basic screening survey are present (https://www.astdd.org/basic-screening-survey-tool/), so this data is compliant if you are required to use that format.

In the Calendar, select the date range. In the first calendar select the start date. In the second calendar select the end date.

Click OK to see the results in the Query window.
The data is intended to be exported to a text file and sent to a centralized office where it gets loaded into one larger table containing data from many locations. For instance, all data for an entire state could be sent to a central office once per month. The data format makes it easy to automate grouping and reporting.

Raw Population Data Report

In Standard Reports (1278), in the Public Health area, click Raw Population Data.

This report is for Public Health (71). It produces a list of patients who had treatment during a specific date range. The resulting data is presented as a single table, with each patient shown on one row.

Calendar: Select the date range. In the first calendar select the start date. In the second calendar select the end date.

Adjustments types for broken appointments: Select the adjustment type your practice uses for broken appointments. Press Ctrl and click to select multiple types. Break Appointment (55)
Click OK to see the results.

The data is intended to be saved to a text file and sent to a centralized office where it gets loaded into one larger table containing data from many locations. For instance, all data for an entire state could be sent to a central office once per month. The data format makes it easy to automate grouping and reporting.

UDS Report

In Standard Reports (1278), in the Public Health section, click FQHC Dental Sealant Measure.

UDSFQHC sealant measure report We have one built in UDS report for the FQHC sealant measure (version 17.1). It replaces query 1092.

- Total Denominator: Total number of patients in the report year who were 6 - 9 years of age, had at least one oral assessment or periodic oral evaluation (completed D0120, D0145, D0150, D0180, or D0191), and who are at moderate to high risk for caries (have a completed D0602 or D0603.)
- Total Numerator: Total number of patients in denominator who have a permanent sealant on a first molar.
- Total Percentage Met: The percentage of patients who have a permanent sealant on a first molar.
Note: Report results exclude children who have molars that are decayed, filled, currently sealed, or unerupted/missing (has a specific set of filling or sealant procedure codes.)

Enter the year to report on.

Click OK to generate the report.

Federally Qualified Health Centers (FQHCs)

Generally Federally Qualified Health Centers provide medical services, and sometimes they perform dental services. Open Dental can work for certain FQHCs that perform dental services.

Current Features:

- **EHR-certified 2014 Edition.** Generally you will use your medical software to attest for EHR and Open Dental for dental charting only. Other situations are possible. Please call us to discuss.
- **Generic HL7(784)** Protocols: for interfacing with medical software.
- **UDS Report(1374)** for Sealant Measure (see below)

EHR Patient Export

This tool is useful when you want to export a summary of a patient's health information as an xml file.

In **Standard Reports(1278)**, click **EHR Pat Export.**
Filter the list of patients as needed. If you change criteria, click Search.
- by First Name, Last Name, PatNum
- by primary provider
- by clinic
- by site (Site List(1272))

Highlight the patients for whom to export information. Or click Select All to select all patients.

Click Export Selected, then select a location to save the files to.

The xml files will be saved by patient Last Name, First Name, PatNum in a single folder labeled by date (e.g. 2015_4_1 is a folder created on April 1, 2015). If patient information is missing, their information will not export and you will receive a notification.

Graphic Reports
Graphic reports are used to quickly compare and analyze trends and data.

In the Main Menu(592), click Reports(1276), Graphic.
Note: There are two security permissions that determine if a user can access graphical financial reports for other providers.

- **Graphical Reports**: Allows a user to access the graphic reports.
- **Production and Income - View all Providers**: User can access graphic Production and Income reports for all providers. If a provider does not have this permission, they can still view their own reports, but only when they are logged on.

There are five types of graphic reports:
- Production
- Income
- Accounts Receivable
- New Patients
- Broken Appointments

Each report can show results for the entire practice, by provider or clinic, and for a specific date range. To customize report settings, see Graphic Reports Setup(1379).

Reports are grouped first by tab, then by cells in columns and rows.

- To customize tabs and reports, click Setup.
- To quickly refresh the data in every graphic report, click Refresh Data.
- Hover over a specific point or column in results to display more details.
- If a legend shows on the report, click a legend item to quickly hide/unhide it in the report results.
- Hover over a report to display three clickable icons:
  - Refresh the data in the report.
Print or export the report data.

Temporarily edit report criteria. These changes will immediately affect the report view, but will not be saved.

Note: General practice data is colored blue. Data grouped by provider is based on the provider color.

Print, Export, Save Graphic Reports
A single graphic report can be printed or exported, or you can print or save a PDF version of all graphic reports currently displaying on screen.
- To print/export a single graphic report, hover over a report, then click the Print/Export button.
- To print/save a PDF of all reports currently displaying, click Print Page in the upper right corner.

Change print/export settings as desired. The displayed image will reflect any settings.
- **Chart Size**: The width and height of the image to print/export, in pixels.
- **Margins**: Any additional margin to add, in pixels. Width adds additional margin to the left margin. Height adds additional margin to the top margin.
- **Chart Position**: Changes the position of the X and Y axis.
- **Landscape**: Check to print, save, or export the report in Landscape orientation. Uncheck to print, save, or export in Portrait orientation.
- **Export**: Save a PDF of the graphic report(s).
- **Print**: Print the graphic report(s) to the default printer.
- **Close**: Close the Print Settings window.

**Graphic Reports Setup**

Graphic Reports Setup Mode is where you can change graphic report tabs, the reports in each tab, and the settings for each individual report.

In the Graphic Reports window, click Setup.

The Graphical Setup permission is required.

**Exit Setup**: Close Setup Mode.

**Refresh Data**: Update the data in all reports.

**Default Graphs**: Add or restore default reports for practice, clinic, and/or provider.

**Reset A/R Graph Data**: Re-run aging for months reported in any A/R graphic report. Warning: This may take a significant amount of time.

**Organize Graphic Reports**
Use tabs to organize graphic reports. Each tab can contain an unlimited amount of reports.
- Double click a tab header to rename a tab.
- Click Add Tab to create a new tab.
- Click the red X to remove a tab. Tabs can only be removed when there are no reports within.

Reports are organized by cell in rows and columns.
- Click Add Column to add a new column of empty cells.
- Click Add Row to add a new row of empty cells.
- To add a new report, drag a Graph Type to an empty cell.

Hover over a report in a tab to view individual report options:

- ![Delete an entire column of empty cells (column to be deleted will be outlined in red).](image)
- ![Delete an entire row of empty cells (row to be deleted will be outlined in red).](image)
- ![Remove a report from a cell (report to be deleted will be outlined in red).](image)
- ![Drag a report to a different cell.](image)
- ![Refresh the report data.](image)
- ![Open the Print Settings window. See Print/Export a Report.](image)
- ![Edit the report criteria.](image)

**Customize Individual Reports**
To customize a report, hover over the report, then click the Edit icon.
- If you are in Setup Mode, changes to criteria can be saved.
- If you are not in Setup mode, changes can be dynamically viewed, but will not be saved.

The Edit Cell window will display report options as well as a preview of the report.
Below is a description of options. Options will vary depending on the graph type.

**Group By Provider/Clinic:** Only shows when using Clinics. Determines how report results are grouped.

Report specific options: These options only show on specific reports, usually at the top.

- **Included Production Sources:** The production sources to consider when generating a Production report. Options include Completed Procs (Procedures), Adjustments, and Writeoffs.
- **Included Income Sources:** The income sources to consider when generating an Income report. Options include Pay Splits (Patient Payments) and Insurance Claim Payments.
- **Count By:** The criteria used to calculate the number of broken appointments in a Broken Appointments report. Options include Procedures (D9986, D9987, or both), Appointments left on the schedule, or a specific adjustment type. If an adjustment type, click the dropdown to select.

**Chart Title:** The header for the report.

**Display:** The X axis (quantity). Options vary depending on the graph type.

- Production $: Production dollar amount, based on included production sources
- Count Procedures: A count of Procedures.
- Income $: Income dollar amount, based on included income sources.
- Receivable $:
- Count: Number of broken appointments, based on the Count By logic.
- Count Patients: Number of new patients. Patients are considered 'new' when they have their first completed appointment in the date range.

**Series Type:** Display options for plotted data.

Stacked Area
Group By: The Y axis (time interval). Options include days, weeks, months, or years.

Legend: Where to show a report color legend (e.g. identify colors by provider or clinic). To hide the legend, select None.

Filter Dates: The report date range.
- Quick Range: Select the general data range for the report.
- From/To: If Quick Range is custom, select a from/to date.

Series Grouping: Select additional grouping options for report data.
- All: Display data by providers/clinics.
- Top: Group data by top providers/clinics versus all other providers/clinics. For example, to compare the top producing provider with all other providers, select 'Top, 1, provider'. The resulting chart will have two groupings: 1) the top producing provider, 2) all other providers.
- None: Only display data for the entire practice; do not separate by provider/clinic.

User Query
Compose queries to retrieve information from your database not accessible through standard reports.
In the Main Menu, click Reports, User Query.

![Query window](image)

See our QuickTip video Find and Run a Query in Open Dental.

The Query window opens when a user with the User Query Admin.

**Text Box:** Displays the query text. If you have User Query Admin permission, you can enter text directly in this box. If you do not, it is disabled.

**Favorites:** Open Query Favorites.

**Add to Favorites:** Add the query text currently in the text box to Query Favorites.

**Copy:** Copy the query text in the text box to the clipboard.

**Paste:** Paste any text currently on the clipboard into the text box.

**Submit Query:** Run the query text currently in the text box. When long queries are run, the Submit button will change to Stop Execution. Click to cancel a large query that may take a long time to run.

**Format:** Select how to view the results.
- **Human-readable:** This is an easy to read format. Some column names that are used in our tables may display as follows:
  - Dates may be converted to standard format.
  - Dollar amounts may receive the extra zeros and be right aligned.
  - Enumerations may convert (built-in lists like areas of the mouth, patient status, gender, etc.).
  - Definitions linked to the definition table get converted.
  - Provider numbers will show the provider's abbreviation.
  - Patient numbers will show patient name.
  - True/false: Boolean values will show true/false.
- **Raw Format:** In this format, the results are not as easy to read, for example there may be meaningless numbers or no extra zeros on dollar amounts.
Title: The title of the query in the text box, if one exists.

By default the results will display in human-readable format. If a column header is prefaced with a $, the cells are always formatted as a dollar amount.

To more easily view the query results, there are a few display options.
- Use the vertical and horizontal scrollbars to move up and down, left and right.
- Click a column header to reorder the results in ascending or descending order.
  Note: Results are sorted alphabetically by strings or words. If you want to sort by something else you will need to specify it in the query itself.
- To change the width of a column, drag the splitter bar between the headers.

Once the table displays the way you want it, there are several options:
- **Print Preview:** View the query like a printed report. Some columns will show a grand total at the bottom of the report while in preview mode. You can Zoom in or use the blue arrows to scroll through pages. Click Query View to return to regular query view.
- **Print:** Print the query to the default printer.
- **Export:** Save the file as a tab delimited txt or xls file to use in another program (e.g. Microsoft Word or Excel). Typical uses include letter merge, spreadsheet analysis, or financial imports. Set the default folder for exported queries in Data Paths Setup (824) (OpenDentalExports).

Hints:
- To include a title/header on printed query results, save the query to your Query Favorites, and enter the title. Then, run the query again.
- Advanced users can run queries directly on the database from outside programs using ODBC or other methods.

- **Note:** To also run command queries, user must also have the Command Query permission.
- If using Random Primary Keys, queries with CREATE TABLE or DROP TABLE syntax can only run on the computer named as the User Query Server on the Replication Setup window (Replication).

**Find a Query**

- **Query Favorites** (1385): Access a customizable list of queries that are used often in your practice. Designated users can only run released queries. User Query Admin permission is needed to add, edit, and delete query favorites, as well as control which queries can be run by others.
- **Query Examples:** Search through more than 1000 queries that have been commissioned by our customers, then copy/paste into Query Favorites or the Query window.
- **Custom Queries:** For a fee, Open Dental can write custom queries for you. You must currently be on support.
- Write your own query, then run and/or save it to your favorites.

Security: Access to queries is controlled by user Security Permissions (1118).
- User Query: User can only run released queries from the Reports, User Query submenu.
- User Query Admin: User can run queries, and edit, add and delete query favorites.
• Command Query: User can run SQL commands (non-select queries)

Programming Resources, Database Documentation has a list of tables and columns in the Open Dental database.

Query Favorites
In User Query(1382), click Favorites.

Alternatively, in the MainMenu(592), click Reports, Queries, then click Favorites on the Query window.

Query Favorites is a place to store frequently used queries, run queries, and control user access to queries. From here you can run, add, edit, and delete query favorites.

Security permissions control how much access a user has to queries.
• User Query: User can only view and run released queries from the Query Favorites list.
• User Query Admin: User can run all queries, as well as add, edit, or delete query favorites.

Run a Query Favorite
Open the list of query favorites. There are two methods:
• Users with only the User Query permission: In the MainMenu(592), click Reports(1276), Released Queries.
• Other users: In the Main Menu, click Reports, Queries, then click Favorites on the Query window.
All queries the logged-on user has permission to run will display. If a user has the User Query Admin permission, a column that indicates released status also shows. Click Show Text to open a separate panel that shows the text of the selected query. Click Hide Text to close the panel.

Type a keyword in the search to narrow results. Double click the query to run.

If there are variables in the query that need defined, the Query Variables window will open. For each variable, double click in the Variable column, enter a value, then click OK. Or simply click in the cell to enter.

Hint: Many queries include comments about each variable. Click Show Text to open a separate panel that displays the full query text with the associated comment highlighted.
Click OK to run the query. The results will display in the Query window.

**Edit a favorite query**

The text in a query can be changed, and its status can be switched between released/not released. The *User Query Admin* permission is required.

On the Query Favorites window, highlight the query, then click **Edit**.
Title: Enter the title of the query.

Released: Determines who can run and edit this query. Status is indicated in the Query Favorites window, Released column.
- Checked: This query can be run by users with the User Query permission.
- Unchecked: This query can only be run and edited by users with the User Query Admin permission.

Prompt for SET statements:
- Checked: Prompt the user to define user variables (e.g. date range, providers, etc.).
- Unchecked: Do not prompt the user to define user variables. Change variables in the Query Window instead.

Query Text: Copy/paste or change the query text as needed.
Export File Name: Optional. Enter the default file name to use when this query data is exported.

Add a new query favorite
The User Query Admin permission is required.
1. On the Query Favorites window, click +New. Or on the Query window, click Add to Favorites.
2. Enter the Title, Query Text, Export File Name, and mark the query as released or not released.
3. Click OK to save.

Add a query example as a favorite:
1. Locate the Query Example.
2. Highlight the query text, then right click and select Copy.
3. In the Query window, click Favorites, then New.
4. Right click in the Query Text box and select Paste.
5. Enter other query details.
6. Click OK to save.
7. The Query will now list as a Query Favorite. We recommend testing it (double-click to run).

Delete a query favorite
The User Query Admin permission is required.
1. On the Query Favorites window, highlight the query to delete.
2. Click Delete.
3. A confirmation message will display. Click OK to delete.

Excel
These steps are provided as a courtesy. Open Dental support technicians do not assist with Microsoft Excel spreadsheets.
You have a couple of options for using your data in an Excel spreadsheet. You can either perform User Query(1382) and export the result, or you can link directly to the database.

Query Export
You can do a query from within Open Dental and export the resulting table. It will normally be saved as a text file in your FreeDentalExports folder on your local C:\ drive. The first row of the text file will contain the names of the columns, and the fields are separated by tabs. This makes it very easy to open in Excel. In Excel, select Data, Import External Data, Import Data to bring up the Select Data Source dialog:
Find your FreeDentalExports folder in the file list, and click on the name of the text file that you exported from Open Dental. The Text Import Wizard has three windows that come up.
1. In window 1, select Delimited.
2. In window 2, select Tab.
3. In window 3, select General.
4. Then click Finish and select where to place the data.

You will now have the entire table loaded into your worksheet for whatever manipulation you wish.

**Direct Link**
Another way to use the data is to directly link to the database. You would not normally need to do this since the text export is simpler, but here are instructions in case you need to. First, set up the ODBC on the computer where you want to access the data. Then, open Excel and open the Select Data Source dialog as shown above. Select New Source at the bottom.
Select Other/Advanced, and click Next.

Select FreeDental from the data source list and enter the username and password. You can click Test Connection to verify that you have a good connection. Select the table you want from the list and then select the new data source you have created. Your table will now be loaded into the spreadsheet for further manipulation.
OpenOffice.org Form Letter

These steps are provided as a courtesy. Open Dental support technicians do not assist with Open Office Form Letters.

You can either do a query and export the result, or you can link directly to the database.

Query Export

You can perform User Query(1382) from within Open Dental and export the resulting table. It will normally be saved as a text file in your OpenDentalExports folder on your local C:\ drive. The first row of the text file will contain the names of the columns, and the fields are separated by tabs. This makes it easy to open in OpenOffice.org. Once the text file has been created, use the following instructions to use it as a datasource for a form letter.

Open a new database in OpenOffice.org.

![Database Wizard](image)

Select the last option as shown and change the type to text. Click Next.
Browse to the path where your text file is located. It won’t let you actually choose your file, but just the folder where it’s located. So it makes sense to use the OpenDentalExport folder which is the same one you set up in Data Paths. The result will be that this connection will also work for any future text files you may save to the OpenDentalExport folder. Also, change the field separator to {Tab} as shown above.

The next window gives you the opportunity to save the connection details as an .odb file. Save the file anywhere you wish, maybe in the OpenDentalExport folder.

Open a new or existing template document in the word processing portion of OpenOffice.org. Once the document is open, go to Tools, Mail Merge Wizard. The wizard has 8 steps. On step 3, you will be attaching the datasource you created above.
Look at the name of the current address list (we have outlined it in red). The name should match the datasource you created earlier. If you need to change it, use the button above to select a different address list. Then, make sure the address in box 3 looks good. You may need to match fields.

Mail merge is complex, but it is very powerful. There are many other techniques and features you could take advantage of to generate quality merge letters. See the instructions for OpenOffice.org to learn more about those other features.

The instructions below were from an older version of OpenOffice.org, but they might still be useful.

**Direct Link**
Another way to use the data is to directly link to the database. You would not normally need to do this since the text export is simpler, but here are instructions in case you need to.

1. Set up the ODBC data source on the computer where you want to access the data.
2. Open a new Text Document and the Data Sources as shown above.
3. Select the database type as ODBC and use the search button at the right to select FreeDental from the list.

**Creating the Form Letter**
As you are creating the letter, you can select Insert, Fields, Other.
You can leave this window floating over your main window as you work, inserting field names as placeholders. You would only insert fields from one table or file within the same letter. Once you have inserted at least one field, you will be able to select File, Form Letter.

From here you can print your form letters. There are many other options and features in OpenOffice.org that will enable you to create high quality form letters. There are templates, variable fields, hidden text, etc.
These steps are provided as a courtesy. Open Dental support technicians do not assist with Open Office Form Spreadsheets.

You have a couple of options for using your data in an OpenOffice.org spreadsheet, the Free alternative to Word/Excel. You can either perform User Query (1382) and export the result, or you can link directly to the database.

**Query Export**

You can do a query from within Open Dental and export the resulting table. It will normally be saved as a text file in your OpenDentalExports folder on your local C:\ drive. The first row of the text file will contain the names of the columns, and the fields are separated by tabs. This makes it very easy to open in OpenOffice.org. First, open a new Text Document. Select Tools then Data Sources.

**Database Wizard**

1. Select database
2. Set up a connection to text files
3. Save and proceed

**Welcome to the OpenOffice.org Database Wizard**

Use the Database Wizard to create a new database, open an existing database file, or connect to a database stored on a server.

What do you want to do?

- Create a new database
- Open an existing database file
- Connect to an existing database

Recently used:

bestcoo

Open...

Click New Data Source at the top, then name your data source whatever you want. Set the type to Text, and select your OpenDentalExports folder as the source using the search button to the right. You will also need to go to the Text tab and change the field separator type to {Tab}. You can also select which tables (files) you want to be made available from the ones on the list.

**Direct Link**

Another way to use the data is to directly link to the database. You would not normally need to do this since the text export is simpler, but here are instructions in case you need to. First, set up the ODBC data source on the computer where you want to access the data. Then, open a new Text Document and the Data Sources as shown above.

This time, select the database type as ODBC. Then use the search button at the right and select FreeDental from the list.

**Inserting Data into the Spreadsheet**

If you are opening a text file, one way is to select File and Open.
First, go to the Files of type list at the bottom. Select Text CSV, which is about half way down the long list and might be difficult to spot. Then, find the file you want to open and click Open.

Another alternative for either text file or database link is to view the data sources as shown below by selecting View then Data Sources, or pressing F4.
The bottom 2/3 of the screen is now the original spreadsheet, and the top 1/3 is the data sources, which are browsable, including all your text file data sources and ODBC data sources. When you find the table you want to load into your spreadsheet, grab and drag the table from the list view at the upper left to the first cell on the spreadsheet below. You can now work with and further manipulate the data.

United Way Reports

Below are some Queries that may be required for United Way.

**Active Patient count by age and gender for patients with first visit date in the date range**

/*United Way Report. Active Patient count by age and gender for patients with first visit date in the date range*/

SET @FromDate='2013-07-01', @ToDate='2013-09-30';

SELECT (CASE WHEN (YEAR(CURDATE())-YEAR(Birthdate)) - (RIGHT(CURDATE(),5)&lt;RIGHT(Birthdate,5))&gt;=120 THEN (YEAR(CURDATE())-YEAR(Birthdate)) - (RIGHT(CURDATE(),5)&lt;RIGHT(Birthdate,5)) ELSE 'NONE' END)
AS 'Age', p.Gender,
COUNT(DISTINCT p.PatNum) AS 'Patients'
FROM patient p
WHERE p.PatStatus=0
AND p.DateFirstVisit BETWEEN @FromDate AND @ToDate
GROUP BY Age, Gender
ORDER BY Gender ASC, Birthdate DESC;

Active Patient count by race for patients with first visit date in the date range
/*United Way Report. Active Patient count by race for patients with first visit date in the date range. ONLY FOR OD VERSIONS BEFORE 13.2*/

SET @FromDate='2014-01-01', @ToDate='2014-02-01';

SELECT p.Race,
COUNT(DISTINCT p.PatNum) AS 'Patients'
FROM patient p
WHERE p.PatStatus=0
AND p.DateFirstVisit BETWEEN @FromDate AND @ToDate
GROUP BY p.Race
ORDER BY p.Race;

Active Patient count for patients with specific health problem with first visit date in the date range
/*United Way Report. Active Patient count for patients with specific health problem with first visit date in the date range. ONLY FOR OD VERSIONS BEFORE 13.2*/

SET @FromDate='2014-01-01', @ToDate='2014-02-01';
SET @ProblemName='%Cholera%';

SELECT (CASE WHEN d.DiseaseDefNum=0 THEN icd9.Description ELSE ddef.DiseaseName END) AS 'Problem',
COUNT(DISTINCT p.PatNum) AS 'Patients'
FROM patient p
INNER JOIN disease d ON p.PatNum=d.PatNum AND d.ProbStatus=0
LEFT JOIN disease ddef ON ddef.DiseaseDefNum=d.DiseaseDefNum
LEFT JOIN icd9 ON icd9.ICD9Num=d.ICD9Num
WHERE p.PatStatus=0
AND p.DateFirstVisit BETWEEN @FromDate AND @ToDate
AND ((d.DiseaseDefNum=0 AND icd9.Description LIKE @ProblemName) OR (d.DiseaseDefNum!=0 AND ddef.DiseaseName LIKE @ProblemName))

**Active Patient count for patients with specific patfield value and first visit date in the date range**
/*United Way Report. Active Patient count for patients with specific patfield value and first visit date in the date range*/

SET @FromDate='2014-01-01', @ToDate='2014-02-01';
SET @FieldName='%Occupation%', @FieldValue='%Dentist%';
SELECT pf.FieldName AS 'PatField',
    pf.FieldValue AS 'FieldValue',
    COUNT(DISTINCT p.PatNum) AS 'Patients'
FROM patient p
INNER JOIN patfield pf ON p.PatNum=pf.PatNum AND pf.FieldName LIKE @FieldName AND pf.FieldValue LIKE @FieldValue
WHERE p.PatStatus=0
AND p.DateFirstVisit BETWEEN @FromDate AND @ToDate
GROUP BY pf.FieldName,pf.FieldValue
ORDER BY pf.FieldName,pf.FieldValue

**Print Screen Tool**
In the [MainMenu](592), click Tools, Print Screen Tool.
The print screen tool is a useful way to capture or print any screen in Open Dental or any other program.

Copy a screen image to the clipboard.
- Press Alt + PrtScr to copy the active window, or
- press Ctrl + PrtScr to copy the entire screen.
- The PrtScr (PrintScreen) key is usually located at the top of the keyboard.

**Zoom +**: Enlarge the image on screen.

**Zoom -**: Shrink the image on screen.

**Print**: Print the image.

**Export**: Export the image to a location on your computer.

---

**Clear Duplicate Blockouts**
In the **Main Menu** (592), click **Tools**, Misc Tool, Clear Duplicate Blockouts.

Duplicate blockouts typically occur after combining operators or after a conversion. Clearing them may improve slowness in the Appointments Module.

Click **Clear** to remove the duplicate blockouts.

---

**Create AtoZ Folder**

In the **Main Menu** (592), click **Tools**, Misc Tools, Create A to Z Folders.

This tool is used to create and share a blank **OpenDentImages** (826) folder.

An OpenDentImages folder is created upon initial installation of Open Dental, so this tool is rarely used.

---

**Database Maintenance for Patient**
The patient level Database Maintenance tool checks the database for improper settings, inconsistencies, and corruption for a single patient.

In the **Main Menu** (592), click Tools, Misc Tools, Database Maintenance Pat.

![Database Maintenance for Patient](image)

This tool is useful for large offices that cannot run a full database maintenance fix during regular office hours.

**Patient**: Defaults to the patient currently selected. Click [...] to select a different patient.

**Checks Tab**

**Patient Specific Database Checks**: Highlight the table checks to perform or click None to deselect all checks. Results will display in the grid.

**Breakdown**: If an X shows in the Breakdown column, double click to see a breakdown of results.

**Show me everything in the log**: Check to include a detailed results log when checking/fixing. Uncheck to show a truncated version of the results.

Select the table checks to run and click **Check** to only run database checks and display results, or click **Fix** to run database checks and fix any errors that do not require a manual fix.

**Hidden Tab**
**Patient Specific Database Checks - Hidden:** Grid lists patient database checks that have been hidden from the main Database Maintenance(1434) Tool.

**Old Tab**
**Patient Specific Database Checks - Old**: Grid lists maintenance checks that are considered deprecated. In most cases these should not be run without explicit direction from Support.

**None**: Deselect all checks in the list. With none selected, all checks will be run.

**Check**: Run selected database checks to detect errors.

**Fix**: Run selected database checks and attempt to fix the errors.

**Merge Discount Plans**
Discount plans can be merged into one and reassign patients as needed.

In the [Main Menu](592), click Tools, Misc Tools, Merge Discount Plans.
Alternatively, in the Main Menu, click Lists, Discount Plans, Merge.

The fee schedules of each plan must differ. This is useful when you create a discount plan by mistake, or want to discontinue a plan.

**Plan to merge into**: Click Change and select the discount plan to keep. This plan will be assigned to all patients who have the from plan.

**Plan to merge from**: Click Change and select the discount plan to remove. Patients who have this discount plan will be reassigned into the plan.

Click **Merge** to combine the plans.

A confirmation message will show. Click **Yes** to proceed. A message will indicate when plans merged successfully. Click **OK**.

---

**Merge Medications**

In the **Main Menu** (592), click Tools, Misc Tools, Merge Medications.

![Merge Medications](image)

Click **Merge** to combine the plans.

---

1406
Merging permanently assigns the *merge into* medication wherever the *merge from* medication is assigned. To run this tool you must have the Medication Merge permission.

Click Change to select the medications from the Medications List (1246).

- **Medication to merge into**: Click Change to select the medication that will remain.
- **Medication to merge from**: Click Change to select the medication that will merge into the above medication.

Click Merge.

To confirm the merge, click Yes. If the generic numbers, medication names, or RxCUIs differ, you will be notified and informed of how many patients have the *merge from* medication in their list.

Click OK to proceed.

A Done message will show when the merge is complete. The *merge from* medication will no longer appear in the master Medication list and any patients with the *merge from* medication will have the *merge into* medication instead.

**Merge Patients**

The Merge Patients tool can be used to merge duplicate patient accounts into one.

In the Main Menu (592), click Tools, Misc Tools, Merge Patients.
Patient to merge into: Click Change to select the patient accounts that will remain. If you bridge to an imaging software, the patient account linked to the images should be retained.

Patient to merge from: Click Change to select the patient accounts that will be merged into the top patient.

Click **Merge**. A message will show when the merge is successful.

Patient first name, last name, and birthdate do not need to match. If the patient first name, last name, and birthdate do not match, a warning message will pop up. Click Yes to merge the patients anyway, or No to cancel.

Patient merges are permanent and cannot be undone.

After the merge:
- The status of the merged from patient will change to **Archived**. The patient can still be accessed via the Select Patient window by selecting **Show Archived/Deceased/Hidden Clinics** and **Show Merged Patients**. The merged patient will only show in the **Family Module**(59) or **Account Module**(150) when the merged patient is selected.
- Duplicate information (e.g. insurance, recall) will need manual cleanup.
- If user attempts to schedule an appointment for the merged from patient, he will be prompted to switch patients.
- History for both the merge from and to patient can be viewed in the **Audit Trail**(1424).
- If the merge to patient is moved into another family, the merge from patient is moved as well.
- As a second step, consider deleting the patient in the Family module.

**Merge Providers**

The Merge Provider tool can be used to merge duplicate providers.

In the **Main Menu**(592), click Tools, Misc Tools, Merge Providers.
Merging permanently assigns the *merge into* provider wherever the *merge from* provider is assigned throughout the entire database (including, but not limited to adjustments, appointments, claims, payments, procedures, etc.). It also removes the *merge from* provider from the Providers (1252). To run this tool you must have the Provider Merge security permission.

Merging providers cannot be undone. Only merge providers when they are the same individual/entity and only when necessary.

Note: To reassign patients from one provider to another, consider moving or reassigning providers instead. See the Provider List.

**Show Deleted**: Check this box to select from hidden and deleted providers.

**Provider to merge into**: Click Change to select the provider that will remain.

**Provider to merge from**: Click Change to select the provider that will merge into the above provider.

Click **Merge** to combine the providers.

To confirm the merge, click Yes. If the full names or NPIs don't match, you will be notified and informed how many patients and claims are assigned the *merge from* provider.
Click OK to proceed.

A Done message will show when the merge is complete.

Providers that have been merged into another provider are still viewable in the Provider List. Click Show Deleted.

The *merge from* provider assignment will not be replaced in Public Health Screening (1457) or LabCorp HL7 (786) lab orders.

**Merge Referrals**

The Merge Referral tool can be used to merge duplicate referrals.

In the Main Menu (592), click Tools, Misc Tools, Merge Referrals.

Merging referrals permanently assigns the *merge into* referral to all patients with the *merge from* referral. It also removes the *merge from* referral from the Referral List (1268). To run this tool you must have the Referral Merge security permission.

**Referral to merge into:** Click Change to select the referral that will remain.

**Referral to merge from:** Click Change to select the referral that will merge into the above referral.

Click Merge.
To confirm the merge, click Yes. If the referral names, titles, and is person/is doctor settings don't match, you will be notified and informed how many patients are assigned the merge from referral.

Click OK to proceed.

A Done message will show when the merge is complete.

**Move Subscribers**

In the Main Menu, click Tools, Misc Tools, Move Subscribers.

The Move Subscribers tool moves subscribers of one insurance plan to another insurance plan. It is useful at the beginning of a benefit year when insurance plans may change for a group of subscribers. To run this tool you must have the Insurance Plan Change Subscriber security permission.

- Note: Moving subscribers is irreversible. Make a full backup before running this tool.
This tool may take several minutes to run. Consider running it after business hours or when network usage is typically low.

Insurance estimates for treatment planned procedures will be recalculated based on the new plan.

**Ins plan to move subscribers to**: Click [...] to select the insurance plan that subscribers will be moved to.

**Ins plan to move subscribers from**: Click [...] to select the old insurance plan. Patient-specific benefits, subscriber notes, benefit notes, or effective dates in this plan will not be retained in the move. This plan will be marked hidden after the move.

Note: To view a selected plan's details, click View.

Click OK.

To continue, click OK. It may take several minutes for the tool to run. When the move is complete, a notification message will show.

Service Manager

In the **MainMenu**(592), click Tools, Misc Tools, Service Manager.
The Service Manager is a tool included in the Open Dental application folder to manage installation of Open Dental Services.

- **OpenDentalService** (1415) (required for necessary background processes and installed with Open Dental)
- **eConnector** (1520): Shared by all eServices.
- **OpenDentalHL7**: Used by **Generic HL7** (784) or **eClinicalWorks HL7** (793).
- **OpenDentalCustListener**: In version 15.3 and earlier, this service was shared by all eServices.

All installed Open Dental Services will list. Each service must have a unique service name and the name must begin with `OpenDent`.

Note: In version 16.2 and earlier, follow the steps to open Service Manager.
1. Locate the Open Dental application folder. Depending on how Open Dental was installed, this may be **C:\Program Files (x86)\Open Dental** or **C:\Open Dental**.
2. Double click on ServiceManager.exe to open.

**Add/edit a service**

1. To install a new Open Dental service, click Add. To modify an existing installed service, double click it.
In the example above, OpenDentalHL7_DatabaseA is paired with the name of the corresponding database.

2. Enter or choose the **Service Name**. It must begin with OpenDent (e.g. OpenDentalService). The service name cannot have spaces.

3. Click **Browse** and select a supported service executable. Typically the files are located in the folders below:
   - `\Program Files (x86)\OpenDental\OpenDentalEConnector\OpenDentalEConnector.exe`
   - `\Program Files (x86)\OpenDental\OpenDentalService\OpenDentalService.exe`
   - `\Program Files (x86)\OpenDental\OpenDentalHL7.exe`
   - `\Program Files (x86)\OpenDental\OpenDentalCustListener\OpenDentalCustListener.exe`

4. Click **Install**. If the installation is successful the status will change from **Not installed** to **Installed, Stopped**.

5. Click **Start** to start the service. The status will change to **Installed, Running**.

**OpenDentaleConnector Service Rules:** Only one OpenDentaleConnector can be installed per database.

**Updating Open Dental Versions:** If a service does not restart itself after an update, you must manually restart it.

**Multiple Databases Hosted on a Single Server**

Multiple OpenDental, HL7, and/or eConnector services can run on the same server to allow one server to host multiple customer databases. In order for each service to process messages for the correct database, a copy of the Open Dental application folder has to be made and uniquely named. In the example above, three such folders were created in the following locations:

- C:\OpenDentalHL7_DatabaseA
- C:\OpenDentalHL7_DatabaseB
- C:\OpenDentalHL7_DatabaseC

Each folder has the exact contents of the Open Dental application folder with a unique `FreeDentalConfig.xml` (607) file. `FreeDentalConfig.xml` file is how each service determines which database it is processing messages for. See [Generic HL7](784) for information about how a connection to the database is established using this configuration file.

**Troubleshooting**

If the service does not start as expected, see the Troubleshooting section on [Generic HL7](784), [eClinicalWorks HL7](793), or [eServices Troubleshooting](1528).

**Problem:** Receive Windows security errors when trying to install Open Dental services.

**Solution:** Contact Open Dental support and we can install them for you.

**OpenDentalWebConfig.xml Errors:**

**Event Log:** If the service does not start as expected:

1. Check to make sure the database folder is correct in the OpenDentalWebConfig.xml file.
2. The service will not start if the version is not exactly the same as the version of the main Open Dental program.
3. If it still won't start, look in the Computer Management tool.
   - Right click on My Computer and select Manage
- Expand System Tools, Event Viewer, Windows Logs, then click on Application.
- You can filter this event log for Event Source ‘OpenDentWeb’. The error and information entries will help determine the reason why the service will not start.

Changing Log Level: It may be necessary to increase the Log Level which is committed to the Event Log referenced above.
1. Right-click on the OpenDentalWebConfig.xml file, then select Open With, Notepad.
2. Add a node (or modify if it is already there) under the &lt;ConnectionSettings&gt;
   node which is called &lt;LogLevelOfApplication&gt;. Set the node value to one of the supported value listed below.
   - Error – The default, lowest logging level. This will only show errors in the event log.
   - Information – This shows Error entries plus inbound and outbound traffic information. This level will clutter your log file but lets you know how frequent your traffic is.
   - Verbose – This shows Error entries plus Information entries plus program troubleshooting information. This mode should be used very sparingly as it will clutter your event log very rapidly. **NOTE: This mode will generally only be used by engineering in the event that there is an issue that cannot be solved by support. It is not recommended to set the log level for long periods of time.

Stop Open Dental Services
See Service Manager(1412).

If you use eServices, HL7, or eClinicalWorks, Open Dental Services must be stopped before you update the Open Dental version on the server.
- HL7(784): OpenDentalHL7 service.
- eClinicalWorks(793): OpenDentalHL7 service.
- eConnector(1520) (OpenDentalEConnector). Used by all eServices.

In version 15.2 or greater, all OpenDent services are automatically stopped prior to an update, then restarted when complete. Prior to version 15.2, you must manually stop and start services.

The steps for stopping the service are as follows.
1. As part of the ordinary update, close Open Dental on all workstations.
2. Stop the service. Open the Computer Management Tool by right clicking on My Computer, Manage. Under Services and Applications, locate the service, then right click and select Stop.
3. Update one computer to the new Open Dental version and get Open Dental running well on that computer. If you are also using the Middle Tier, perform the first update on that computer. This may not be the same computer as the HL7 or database server.
4. Update the other computers.
5. Restart the service. Follow Step 2 but select Start.

Note: If you do not stop the service, follow the steps to stop it, then repair the Open Dental installation.

Open Dental Service
The Open Dental Service is used to run background processes necessary for Open Dental.

In the Service Manager(1412), double-click OpenDentalService.
The OpenDentalService will only list in the Service Manager on the server computer. The service should only be installed on the server, since additional installations on workstations may cause conflicts.

This service is required for customers using Email (1660), eServices or customers utilizing certain third parties.

The OpenDentalService does the following:
- Creates an alert:
  - if the number of current MySQL connections is greater than the max_connections variable in the my.ini file.
  - when payments are made from the Patient Portal (1555).
  - when a Web Sched New Patient (1586) appointment is created.
  - when a Web Sched Recall (1600) appointment is created.
- Downloads email from servers based on the Inbox Receive Interval set in Email Setup (747).
- Runs aging once a day if Aging is enterprise preference is selected. See Enterprise Setup (904).
- Imports clearinghouse reports if Receive Reports by Service is checked in the E-Claims window.
- Send patient aging information to TSI Collections (527).
- Sends information from Podium if Use service to send invitations is checked in the Podium (1047) program link.
- Runs CC Recurring Charges (1430).
- Adds charges for Dynamic Payment Plans.

Installing the OpenDentalService
The OpenDentalService is typically installed on the server computer upon initial installation of Open Dental.

Sometimes the OpenDentalService must be installed manually due to permission restrictions on the server.

To manually install the OpenDentalService:
1. In the Main Menu, click Tools, Misc Tools, Service Manager.
2. Click Add.
3. Click Browse and select the OpenDentalService.exe. This is typically located in \Program Files (x86)\OpenDental\OpenDentalService\.
4. Click Install.
   1. Enter your configuration settings.
   2. Click OK to close the Configuration window.
   3. If the installation is successful, the status will change from Not Installed to Installed, Running.

Procedure Lock
In the Main Menu (592), click Tools, Misc Tools, Procedure Locking.
This option is not used by most offices. Completed Procedure Notes (316) and any edits made are automatically recorded in the database and cannot be deleted. An archived history of notes on a completed procedure can be viewed in the Chart Module (298) under Show tab, Audit.

To lock procedures for a specific date range at one time, use the Procedure Lock Tool. This tool is only visible in the menu when procedure locking is allowed. If you just turned on the procedure locking option in Chart Module Preferences (706), then you will need to restart Open Dental to see the menu option for the Procedure Lock Tool.

Enter the date range and click OK.

**Locking Individual Procedures**

Procedure locking is for the few offices that want to lock each completed procedure and only allow notes to be appended. If you use this option, there is no way to unlock a procedure, regardless of security permissions. In the case of mistakes, you can mark locked procedures as invalid. This preference can be turned off later, but locked procedures remain permanently locked.

To change the lock setting, see Chart Module Preferences (706), Procedure Locking Allowed.

If locking is allowed, completed procedures will have a Lock button on the right side of the Procedure (303).

When you click Lock, the procedure is immediately and permanently locked. You may only view the procedure, append procedure notes, or invalidate the procedure.

**Appending Notes**

Appending a note adds an additional note to the original procedure note. Click Append.
Enter the new note in the **Appended Note** text area, or add an **Auto Note** (317). Appended notes are dated, and appear in the Progress Notes below the procedure. Appended notes can be signed electronically, see **Electronic Signatures** (306).

**Invalidating**
Locked procedures cannot be edited, only appended. If you make a mistake, the only allowed method is to invalidate it on the **Procedure** (303). It will still appear in the Progress Notes, but it will be grayed out and **Invalid** will appear in the description. You will then have to recreate the procedure.

**Shutdown Workstations**
In the **Main Menu** (592), click Tools, Misc Tools, Shutdown All Workstations.
Use this tool to shut down the Open Dental program from any workstation that might be running. Click **Shutdown** to end the program.

When updating Open Dental versions, the following window will appear if Open Dental has not been shutdown on all workstations.

Click OK to continue.

**Telephone Numbers**
In the **Main Menu** (592), click Tools, Misc Tools, Telephone Numbers.

![Telephone Tools](image)

This tool will reformat telephone numbers in the following places:
- Patient phone numbers
- ICE phone numbers on patient notes
- Carrier phone numbers

Click **Reformat**.

The matches that will be reformatted are as follows:
- ############
- ####-####-
- ######-####
- #######-
- ######-
- (###) ####-
- (###) ####
- ############

**Test Latency**

In the **Main Menu** (592), click Tools, Misc Tools, Test Latency.
The Test Latency tool can be used if you are experiencing network slowness.

- **Latency**: Measures turnaround time (how long it takes your computer to travel to the database and back). It is measured in milliseconds. The lower the latency, the less delay. Measurements vary from network to network, but on average a good result is less than 50 ms.
- **Speed**: Measures how long it will take to generate a complex query. It is measured in megabytes per second.

Click Test to calculate.

See also: [Troubleshooting Slowness](#)

**Patient Status Setter**

In the [Main Menu](#), click Tools, Misc Tools, Patient Status Setter.

The Patient Status Setter tool can be used to change the patient status of multiple patients at once. The tool filters active or inactive patients who have or have not had planned procedures, completed procedures, or appointments since a specified date. The patient status can also be set manually per patient in the [Edit Patient Information](#).

**Filters**: This criteria determines which patients to change the patient status for. Click **Create List** to update results.

- **Active patients without**: Check to find active patients who do not have planned procedures, completed procedures, or appointments in the *Since* date range. This will set their patient status to inactive.
• **Inactive patients with**: Check to find inactive patients who have had planned procedures, completed procedures, or appointments in the *Since* date range. This will set their patient status to active.
  o **Planned Procedures**: Select to find patients who have not had or have had procedures attached to planned appointments that are not yet complete and with a Date in the *Since* date range.
  o **Completed Procedures**: Select to find patients who have not had or have had procedures completed in the in the *Since* date range.
  o **Appointments**: Select to find patients who have not had or have had an appointment in the *Since* date range.
• **Since**: Use the drop down menu to select the date since field, or manually type in the date. This date will default to two years prior to today.
• **Clinic**: Use the Clinic drop down to limit the results to a specific clinic.

**Patients to Convert**: List of patients for currently selected criteria.
• **Patnum**: Patient account number.
• **PatStatusCur**: Current patient status.
• **PatStatusNew**: Patient status after tool is ran.
• **First name**: First name of the patient.
• **Last Name**: Last name of the patient.
• **Birthdate**: Birthdate of patient.
• **Clinic**: Clinic the patient is assigned too.

**Select All**: Click to select every patient in the list.
**Deselect All**: Click to deselect all the highlighted patients in the list.
**Run**: Click to change the status of the selected patients.
**Close**: Click to close window.

**Changing the Patient Status**
To change active patients to inactive, select **Active patients without**. To change inactive patients to active, select **Inactive patients with**.

Select **Planned Procedures**, **Completed Procedures**, and/or **Appointments**. At least one option must be selected.

Select date range
If using Clinics select desired clinic.

Click **Create List** to view active or inactive patients that meet the filter criteria.
Select one or more patients and click **Run**. Click **Yes** to change the status of the selected patients.

![Confirmation Window]

This will change the status for selected patients from Patient to Inactive.
Do you wish to continue?

Yes  No

When the tool has finished a confirmation window will open with a list of patients that were updated. Click **Print** to print the list or **OK** to close.
Aging

In the MainMenu(592), click Tools, Aging.

Aging is automatically calculated when you open the Account Module(150), run the Repeating Charges(1465) tool (if checked), run Billing/Finance Charges(1428) and Billing(504), generate the Aging of Accounts Receivable (A/R) Report(1308), or generate the Insurance Aging Report(1338). By default, aging is calculated daily.

To set a specific time to run aging and/or prevent slowness due to aging (for larger offices), see Miscellaneous Setup(921):

- Automated aging run time
- (Enterprise users) Aging for enterprise Galera cluster environments using FamAging table

Manually Calculate Aging

If you have opted in Account Module Preferences(693) to have Aging calculated monthly instead of daily, you will need to manually update patient aging. Typically you will update near the beginning of the month.

Enter the Calculate as of date, then click OK. The default date will be one month after the last calculated date, but can be changed as needed.

Note: An entry is made the Audit Trail each time Aging is ran.
How Aging is Calculated
By default, all charges within a family are sorted into four aging categories based on the date of the charge. The categories are 0-30, 31-60, 61-90, and over 90 and represent the number of days the remaining balance of a charge has been outstanding. Then, the sum of all credits for the entire family history is applied to the oldest category with a remaining balance. If the total credits were not sufficient to cover the total charges, categories will still contain amounts due.

Credits are applied to the oldest debts first in order to give the family as much credit as possible. This way, if you see a family has a balance in the over 90 category, you might be more comfortable moving the guarantor account to precollections. However, this may be changed, so credits attached to a procedure are applied to the procedure balance instead of the oldest family balance. See the Account Module Preference, Transactions attached to a procedure offset each other before aging.

Audit Trail
The audit trail is a log of actions taken by users.

In the MainMenu(592), click Tools, Audit Trail.

For the audit trail to contain complete information, you must set up user profiles for all staff that access Open Dental and assign security permissions to user groups. See User Edit(1109) and User Group(1115).

Filtering Options
- **From/To date**: Show logs for a a specific date range. If you change the dates, click Refresh to update the list
- **Permission**: Show logs for a specific permission.
- **User**: Show logs made by a specific logged-on user.
- **Patient**: Only show entries for a single patient.
  - **Current**: Show entries for the currently selected patient (the patient that was selected before you opened the audit trail).
  - **Find**: Select a Patient(1649).
  - **All**: Eliminate patient as a filter so that all entries show.
- **Show Archived**: Include entries from an archived database. Only used when archiving databases. See Backup Tool(539).
- **Limit Rows**: By default, up to 500 log entries are listed at a time. You can manually change the number then click Refresh to update, or change the default in Miscellaneous Setup(921).
- **Previous From Date / To Date**: Search by the date a permission was last edited. If blank, all edits will show.

Click Print to print the audit trail to the default printer.

Only users with the Audit Trail permission can view the main audit trail. There are also several smaller audit trails that don't require the permission:
- Appointment audit trail (a log of when an appointment was created, moved, edited). See Edit Appointment(20).
- Chart audit trail (a log of changes made in a patient's Chart). See Show Chart Views(328).
- Insurance audit trail (a log of changes to the insurance plan). See Insurance Plan(81).
• Task level audit trail (a log of changes made to a task, if using the Task system). See Task Window (1698).

Audit trail entries are never changed within Open Dental and should never be changed outside of Open Dental.

Actions are listed by date/time, with the most recent change at the end of the list. Some actions may result in two log entries, one with details, and one with the last date edited. If a patient is selected when the audit trail is opened, only log actions related to the patient are shown by default.

• Date/Time: When the action occurred (date and time).
• Patient: The patient who was accessed or affected.
• User: The logged in user when the action was performed. If this shows as an unknown user, then it is typically triggered by an automated service from within the program. For example, automated eConfirmations change the confirmation status of an appointment and an unknown user is logged.
• Permission: The name of the tracked security permission. Not all permissions are tracked.
• Computer: The workstation where the action was taken.
• Log text: Additional information about the action taken.
• Last Edit: Date and time of last edit. If this is blank, there is no data to display. This can happen when the item doesn't track dates or when an item is new and has no previous modifications.

The following actions are always tracked:
• Every time a user logs on, logs off, or closes Open Dental.
• When anything is printed or copied in Open Dental.

The following appointment-related actions are not tracked:
• No log for locking appointment times for all existing appointments.
• No log for deleting planned appointments from the Chart module.
• No log for changing providers on an appointment during Provider Merge (there is a log entry for the provider merge itself).
• No log for changing PatNums on an appointment during Patient Merge (there is a log entry for the patient merge itself).
• No log for removing an assistant from an appointment.

Open Dental checks to verify the integrity of the audit trail data.
• Black log entries indicate trusted entries; meaning Open Dental has checked and no changes have been made to the log entry since it was created.
• Red log entries indicate non-trusted entries, meaning this log entry failed the check to prove the entry is unchanged. This means the entry was changed outside of Open Dental to something different than the original entry. Some red entries are made by an Open Dental conversion. Other red entries are not made by Open Dental, and it is possible they are malicious or not legitimate.

Ortho Auto Claims
Use the Ortho Auto Claims Tool to generate periodic orthodontic claims. This is useful when a carrier wants a claim submitted for the initial procedure, plus periodic claims based on a set frequency instead of per visit.

Once the initial orthodontic treatment procedure is set complete, the periodic claims are subsequently flagged for auto-generation based on the carrier's desired frequency, procedure, and fee. They will continue to flag for auto-generation until the total treatment time (Total Tx Time) is reached.

How it works:
1. Set general ortho preferences.
2. For each insurance plan, set the Ortho preferences (Insurance Plan (81), Ortho tab). Ortho claim type must equal Initial Plus Periodic to be eligible for auto ortho claim generation.
3. When the patient comes in for their first orthodontic treatment, set the initial orthodontic procedure complete and create the initial claim. This will trigger the next ortho claim date to update based on the plan's frequency.

4. When the current day equals or is after the next claim date, the patient will list as an option when running the Ortho Auto Claims Tool.

5. Generate the ortho claims using the Ortho Auto Claims Tool. The next ortho claim date will auto-populate with the next due date based on the plan's frequency.

**Setup**

The following items must be set up to use the Ortho Auto Claims Tool.

In Ortho Setup(927):

- Check **Show ortho case in account module** so the Ortho Case(275) shows in the Account module and an Ortho tab shows on the Edit Insurance Plan window.
- Set the default procedure code that will be used on orthodontic claims that are created automatically (Default Ortho Auto Proc).
- Check **Mark claims as Ortho if they have ortho procedures** so that Is Ortho is always marked on automatically generated ortho claims.
- Check **Use the first ortho procedure date as Date of Placement** so that the Date of Placement is always filled on automatically generated ortho claims.
- Set which procedures will be considered initial orthodontic procedures (Ortho Placement Procedures).
- Set how users can enter claim payments for claims generated using the Ortho Auto Claims Tool (only enter on initial procedure's claim, or allow to enter on auto-generated claims).
- Set other defaults as needed.

On the Edit Insurance Plan window, Ortho tab, specify the carrier's claim preferences. Any changes made here will affect all patients using the plan.

**Ortho Claim Type**: Select Initial Plus Periodic. Only plans with this option selected can generate claims using the Ortho Auto Claims Tool.

**Ortho Auto Proc**: Select the procedure code to use on auto-generated orthodontic claims for this plan. Set the default in Ortho Setup. Click [...] to select a different procedure.

Note: Only the first 5 digits of procedure codes are sent to insurance. In the example above, only D8670 is sent to insurance. The .auto portion of the procedure code is not sent to insurance, but is useful to identify and track codes on auto-generated claims.

**Ortho Auto Fee**: Enter the procedure fee to bill on the claim. 0 is a valid amount.

**Auto Proc Period**: Select how often the carrier requests a periodic claim (Monthly, Quarterly, Semi Annual, Annual).

**Wait 30 days before creating the first automatic claim**: If the insurance carrier requires that you wait a minimum amount of days after the initial completed procedure before sending the first periodic claim, check this box.

**Schedule the Patient's Initial Treatment Procedure**

As usual, schedule the patient's first initial treatment appointment with the corresponding orthodontic placement procedure.

Schedule the appointment and attach the procedure.
At the time of treatment, set the appointment/procedure complete. Doing so will update the next ortho claim date for the patient based on insurance plan ortho frequency setting.

Check the Ortho Case tab to verify that dates and fees are accurate.

Create the initial orthodontic claim and send as normal.

**Generate Periodic Ortho Claims using the Ortho Auto Claims Tool**

Each month, check the Ortho Auto Claims Tool to see which periodic claims are due to be sent. The next claim date will always be the first of the month.

In the Main Menu, click Tools, Ortho Auto Claims.

![Ortho Auto Claims](image)

Claims that meet the ortho auto claim criteria below will list alphabetically by last name:
- Patient insurance plan is set to create automatic ortho claims.
- The initial ortho treatment procedure has been completed.
- The next claim date is today or prior.

Column definitions:
- **TxMonths**: Total months in treatment.
- **Banding**: The date of the initial orthodontic procedure.
- **MonthsRem**: The number of remaining treatment months.
- **#Sent**: The amount of claims already sent.
- **Last Sent**: The date of the last sent claim.
- **Next Claim**: The date the next claim is due.

Note: Click name of column to change sorting.

Numerical sorting will use the same logic as alphabetical sorting. Rather than 1, 5, 10, you will see 1, 10, 5.

Select the claims to automatically generate. When Clinics is turned on:
- Optionally filter claims by clinic using the Clinic dropdown.
- Click Select All to select all claims.

Click Generate Claims. A confirmation message will show.

Click Yes to generate the claims.

Another message will indicate when the process is complete, the number of claims generated, and the number of procedures added. Click OK.

Click Close to close the Auto Ortho Claims window.

The claim will show in the Account module with a waiting to send status. The Auto Proc Code in the claim (e.g. D8670.auto) will also show in the patient's account. To send, see Send Claims.

**Determining the Next Ortho Claim**

There are two places to view when a patient's next ortho claim is flagged for generation with the Ortho Auto Claims Tool.
- Ortho Case, Next Claim.
• The patient's insurance plan information: In the Ortho Case tab, double click the insurance plan area, or open the patient's insurance plan, then click the Ortho button in the Patient Information area.

![Ortho Patient Setup](image)

The **Next Claim Date** is typically auto-populated based on the last claim (the initial ortho claim or the last auto-generated claim). To change the next date, simply change the date on the Ortho Patient Setup window. This can be useful if you need to skip a periodic claim or stop claims altogether.

A few hints:
• The date will always be the first of any given month, so even if you enter 3/15/2017 it will change to 3/1/2017 upon clicking OK.
• To stop auto generated claims, leave the next claim date blank. There will be no next claim when this field is blank.
• Once you manually set a date, it will not auto-update until the next auto-generation of a claim.

**How do I change the fee billed on the next claim?**
The fee defaults to the fee set on the Edit Insurance Plan - Ortho tab. To override it for the next claim only, uncheck **Use Default Fee**, then enter the new fee.

**Claim Payments**
When generating auto-ortho claims, consider where claim payments should be entered: on the initial procedure's claim or on the auto-generated claim.

To only allow staff to enter claim payments on the initial procedure's claim, check **Consolidate Ortho Insurance Payments** in Ortho Setup. Then enter any installment payments as **Supplemental Insurance Payments** on the original claim and receive auto-generated claims as zero payment claims.

**Billing/Finance Charges**
In the **Main Menu**,(592), click Tools, Billing/Finance Charges.
The Billing and Finance Charges tool is used to apply finance or billing charges to an Account (150). The charges will be applied to all guarantors that meet the filtering criteria entered on this window. Users must have the Setup permission to access this window.

**Billing Charge**: Add a flat charge to the account. The charge will be added to the account as an Adjustment. The adjustment type is determined by the setting in Account Module Setup, *Billing charge adj type*.

**Finance Charge**: Apply a percentage charge (APR) to the account balance. This charge is calculated against the entire balance, not just the patient portion, so you may want to carefully review pending insurance before and after running finance charges. It is recommended that you run it every month for an accurate APR. An **Adjustment** (203) will be added that equals one month (1/12) of APR charges. The adjustment type is determined by the setting in Account Module Preferences (693), *Finance charge adj type*.

- **Charge at least**: Set the minimum finance charge amount. For example, if set to $5.00, any finance charge amount from $0.01 to $4.99 will be charged as $5.00 to the patient.
- **Only if over**: Set the minimum amount of a calculated finance charge before APR is assessed. For example, if the **Only if over** amount is $3.00 and the finance charge is less than that amount, the patient is charged $0.00.
- **If both preferences are set**, the patient will be charged the **Charge at least** amount, but only if it is greater than the **Only if over** amount. If the finance charge is greater than the **Charge at least** amount, the finance charge amount is applied.
- **Compound Interest**: Determines whether or not past interest adjustment charges are considered when calculating new interest charges. Check to charge interest on the total past due amount. Uncheck to charge interest on the past due amount minus any past interest charges.

Note: If the account has an **Installment Plan** (260) setup for any family member, the installment plan’s APR is used instead of the APR set here.
**Date of New Charges**: Enter the date the new charges should be applied.

**Calculate on Balances aged**: Select the age of the accounts that should have the charge added.

**Only Apply to these Billing Types**: Select which billing types should have the charge added.

**Finance/Billing Filters**: Select options to have certain accounts excluded from receiving finance or billing charge.  
- **Exclude bad addresses (no zip code)**: Check to exclude families with a bad address.  
- **Exclude inactive families**: Check to exclude families with an Inactive status.  
- **Exclude if insurance pending**: Check to exclude families with an insurance claims still pending.  
- **Ignore walkout (In person) Statements**: Works in combination with excluding accounts not billed since setting. If checked walkout statements will not be considered as being billed.  
- **Exclude accounts (guarantor) without Truth in Lending**: Check to exclude families that do not have a signed Truth in Lending agreement on record.  
- **Exclude if balance less than**: Set a balance, below which families will be excluded.  
- **Exclude accounts not billed since**: Set a date to exclude families who have not been billed prior to.

**Run**: Click to process finance or billing charges to all included accounts.

To see all the finance charges that were applied, run the Finance Charge Report(1314).

**Undo Finance/Billing Charges**
Use the Undo button to undo your most recent charge (finance or billing). All adjustments made on the same date, which have the same adjustment type, will be deleted. To undo finance charges for a different date, you must manually go into each account and delete the individual adjustment. Use the Finance Charge Report(1314) to identify the adjustments made on that date.

**Apply Both Finance and Billing Charges**
To apply both finance and billing charges to an account, you will run the finance/billing charge tool twice on the same day, once per month. You will still do daily billing.
1. Run the tool to apply the APR finance charge (e.g. 18%) to accounts over 30 days.
2. Run the tool to apply billing charge (e.g. $4) to accounts over 60 days.
3. Send statements.

**CC Recurring Charges**
Use the recurring charges tool to process credit/debit cards or ACH payments for patients who have recurring charges (e.g. payment plans, repeating charges).

In the Main Menu(592), click Tools, CC Recurring Charges.
Run the tool automatically at a scheduled time each day, or manually as needed.

The **Recurring Charges** grid lists patients with a payment scheduled in the last 30 days but not yet processed. Double-click a row to go to that patient's account. This window can be left open to make it easy to view each patient's account.  
**PatNum**: Patient account number.  
**Name**: Patient last name, first name.  
**Clinic**: Patient's clinic or the clinic assigned to the payment plan.  
**Date**: Scheduled recurring charge date.  
**Family Bal**: Total remaining balance for the family after subtracting pending insurance amounts.  
**PayPlan Due**: Outstanding payment plan charges due (only shows if the payment plan is attached to a recurring charge).  
**Total Due**: Total family balance and payment plan charges due.  
**Repeat Amt**: Authorized recurring charge amount.  
**Charge Amt**: Amount that will be charged.

When multiple payment processing programs are enabled, each account in the list indicates the program the card or bank account the **Token** was created for and will use the indicated program to process the payment. If a single credit card has a token for more than one processing program and authorized recurring charges, the recurring charge tool will determine the program to use to process the payment in this order: XCharge, PayConnect, and then PaySimple.  
**X-Charge**: X indicates the credit card token has been saved to X-Charge.  
**PayConnect**: X indicates the credit card token has been saved to PayConnect.  
**Pay Simple**: X indicates the credit card/ACH token has been saved to PaySimple.

Edit the **Date / Clinic Filter** and click **Refresh** to limit or expand the number of patients in the Recurring Charges grid.  
**Date Filter**: Filter the list by patients with a recurring charge date that is on or after the entered date.  
**Clinic Filter**: Check All or select one or more clinics to filter the list by patients with the selected default clinic or the clinic assigned to the patient's payment plan (if the payment plan is set up for recurring charges).  

**Force Duplicates**: Uncheck to prevent more than one charge to the same card in a day. Check to allow multiple charges. Useful if multiple family members use the same card for recurring charges or when a patient has made a payment for other services with the same card today.

Note: Check box does not apply to PaySimple credit/debit and ACH payments. PaySimple will decline identical transactions to the same card made within 5 minutes apart.

The **Counts** section shows the recurring charge progress.  
**Total**: The total amount of recurring charges ready to be run.  
**Selected**: The number of charges that are currently selected for processing.  
**Charged**: The number of charges successfully processed during the most recent run. Patients with successful charges will be removed from the list.  
**Updated**: (For the XCharge Decline Minimizer feature only) The number of credit cards updated by the Decline Minimizer, see XCharge (OpenEdge) below.
Failed: The number of charges that failed to process during the most recent run. When a payment declines, a matching transaction for $0.00, with a note that indicates the decline, will show in the patient's account ledger. Patients with failed charges will remain in the list until the authorized charge is cleared from the Credit Card Manage(277), their account balance is zero, or a payment is applied to their recurring charge.

All: Click to select all patients in the list.
None: Click to deselect all patients in the list.

History: Click to see the recurring charges history. See Recurring Charge History(1433).

Print List: Prints the Recurring Charges grid.

Send: Click to process credit card and ACH payments for the selected patients using the credit card processing program indicated.

Set up Requirements
Before using the recurring charges feature, the following needs to be set up:

- Enable Credit Card Payment(166) with XCharge (OpenEdge)(173), PayConnect Window(168), or PaySimple(186) and store patient's payment information using tokens.
- Enable the preferred Recurring Charges settings in the Account Module Preferences(693) (i.e. provider allocation, payment transaction date, automatic run time, etc).
- Assign the default payment type for credit card recurring charge payments in Account Module Preferences. ACH recurring charges will use the type assigned in the Payment Type ACH dropdown of the PaySimple Setup(1041) window.
- Authorize charges for select patients with a Payment Plan(239) or Repeating Charges(1465). See Authorize Recurring Charges(281).

Automatic Recurring Charges
One option is to run recurring charges automatically at a specific time each day.
1. In the Misc tab of Account Module Preferences, check Recurring charges run automatically.
2. Set the Recurring charges run time.
3. In Miscellaneous Setup(921), enable Automated aging run time. Set the time to run before automatic recurring charges (an hour or more for large offices, 30 minutes for smaller offices).
4. Ensure the computer with the OpenDentalService(1412) (typically the server) is on at the scheduled run times, and the OpenDentalServiceConfig.xml is configured to the correct database. Open Dental does not need to be running but the computer must be on for the service to work.

- Note: X-Web must be enabled with a XWeb ID, Auth Key and Terminal ID entered for X-Charge users to use Automatic Recurring Charges.
- Be aware that failed charges will continue to run daily until successful, or manually stopped.

Everyday run the repeating charges tool before the aging and recurring charges run time (when using the repeating charge feature). Once recurring charges have finished, open the Credit Card Recurring Charges window to take care of the declined payments.

Manually Run the CC Recurring Charges Tool
The other option is to manually run recurring charges at your convenience with the recurring charge tool. Choose a standard day, such as the 1st or 15th of every month to run the tool. If the recurring charge frequency varies with patients, run the tool daily to be sure patient balances are up to date.

Note: Do not run the tool and process charges at the same time on the same computer (e.g. do not have more than one instance of Open Dental running on the same computer, and use one instance to run the tool and another to process charges).

1. Run the repeating charges tool (only if using the repeating charge feature).
2. Make sure Aging(1423) is up to date.
3. If billing is normally done at the same time, Generate the Billing List(507).
4. Generate the Credit Card Recurring Charges list.
5. Select the patients you wish to charge.
6. Click Send to process ACH or credit card payments for the selected patients.
7. Once finished, take care of the declined payments if needed.

**Printing Receipts**
There are a few options to print receipts when recurring charges have finished; statement receipts, credit card/ACH receipts, or Statements.

To print statement receipts or credit card/ACH receipts:
1. In the Credit Card Recurring Charges window, click History.
2. Right-click a patient in the recurring charges list and select Go To Account.
3. Then print/email a statement receipt. See Receipt(271).

Or double-click the recurring charge payment and click Print Receipt or E-Mail Receipt in the Payment window. This will generate a receipt from the processing merchant.

To print statements reflecting the recurring charge payment, generate the billing list prior to running recurring charges. Once charges have posted, send statements.

**Troubleshooting**

**Some patients with authorized recurring charges are not showing in the list. Why?**
There are many reasons a patient might not appear in the list. The following may be some of these reasons:
- Patient's balance is zero.
- The authorized charge is associated to a payment plan that has been paid off.
- A payment has been applied to the scheduled recurring charge. Check the most recent payments in the patient's account. If the *Apply to Recurring Charge* box is checked in the payment window, the recurring charge is not needed for this month.
- Another user may be processing the recurring charge. Check the recurring charge history for pending transactions. To remove a patient from the pending status, right-click and delete the pending charge. The patient will be put back into the recurring charge list.
- Check to make sure the scheduled payment date is on or after the date entered in the Date Filter.
- If a payment plan (that has an amount due) is added to an existing recurring charge that has processed this month, the payment plan will not be charged for the current month. The patient will appear in the list on the next recurring charge date for the previous month's pay plan due amount plus the new month's due amounts.

**The payment date is different than the date the payment was processed. Why?**
If the tool is run on a date other than the patient's authorized recurring charge date, the payment date is determined by the following:
- If *Recurring Charges use transaction date* is checked in Account Module Preferences, the Payment date will be date the charge is run.
- If *Recurring Charges use transaction date* is unchecked, the Payment date will be backdated to the scheduled recurring charge date, unless there is a Security lock date in place to prevent it (Security Lock Dates(1122)).

The Payment Entry date will always reflect the actual date the charge was made.

**Recurring Charge History**
Use the recurring charge history window to view recurring charge transactions in a date range.

In CC Recurring Charges(1430), click History.
Change the **View** filter to determine which transactions display in the Recurring Charges grid.

**From/To**: The date range of transactions. Use the dropdown arrows to select dates or type in the From and To dates.

**Status**: The transaction status.
- Pending: Transactions currently in process by the service or another user.
- Successful: Completed transactions.
- Failed: Declined transactions.

**Clinic**: Filter the list by clinic assigned to the patient or clinic assigned to the payment plan (if the payment plan is set up for recurring charges). Use the dropdown or click [...] to change the clinic.

**Automated**: Filter the list by transactions completed through the service (Automated) and/or recurring charges tool (Manual). Click the dropdown to change.

**Refresh**: Update the Recurring Charges list to reflect the view criteria.

The **Recurring Charges** grid lists patients with recurring charges based on the View criteria. Right-click a row to go to that patient's account or to remove a pending charge and put back into the Credit Cards Recurring Charge list. Only remove a pending charge if you know it is not being processed by the automated service or another user. This window can be left open to make it easy to view each patient's account.

**PatNum**: Patient account number.

**Name**: Patient's last name, first name.

**Clinic**: Clinic assigned to patient or payment plan.

**Date Charge**: Date and time the recurring charge was processed.

**Charge Status**: Status of the recurring charge, pending, successful, or failed.

**User**: The user processing or processed the recurring charges through the recurring charge tool. Column is blank when recurring charges are processed through the automated service.

**Family Bal**: The total remaining balance for the family after subtracting pending insurance amounts at the time the payment was processed.

**Pay Plan Due**: Outstanding payment plan charges due (only shows if the payment plan is attached to a recurring charge).

**Total Due**: Total family balance and payment plan charges due at the time the recurring charge was processed.

**Repeat Amt**: Authorized recurring charge amount.

**Charge Amt**: Amount charged or the amount expected to be charged for pending transactions.

**Close**: Exit the Recurring Charge History window.

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**Database Maintenance**

The database maintenance tool checks the database for improper settings, inconsistencies, or corruption.

In the **Main Menu** (592), click Tools, Database Maintenance.
You can then choose which fixes or tools to run, or follow the provided guidance to correct problems. It should only be run on one computer at a time. If using Replication, database maintenance can be dangerous. Make certain all servers are connected prior to running (e.g. if mobile units). We also recommend making a backup of the database first, then running it after hours. You will need to Force Synchronization after running, then check that replication is still running properly.

- **Note:** Warning. We do not recommend running Database Maintenance during office hours because it can cause severe network slowness.
- Database maintenance repair log files are saved to the A to Z folder in the DBMLogs subfolder.

### Checks Tab

All possible database methods are listed.

- Highlight the methods to perform or click **None** to deselect all methods. When no methods are selected, all database methods will run.
- Right click on a method and select **Hide** to remove the method from the list. Hidden methods show on the Hidden tab.
- **Show me everything in the log:** If checked, when a method or fix is run, the results will include a detailed log. If unchecked, a truncated version of results will show.
- Click **Check** to only run database checks and display results.
- Click **Fix** to run database checks and fix any errors that do not require a manual fix. Some changes made by the Database Maintenance tool are logged in the dbmlog table.
- Click **Stop DBM** to stop the next method check/fix. The current method check/fix will finish.
- **Breakdown:** If an X shows in the Breakdown column, double click to see a breakdown of results.

Every time any check or fix is run, MySQL will check every single table for corruption, so you may notice a delay. As checks are complete, the Results log will update.

**Note:** Galera enterprise users can manually disable the MySQL integrity check by setting the DatabaseMaintenanceSkipCheckTable preference to true. The Optimize button under the Tools tab can be disabled by setting the DatabaseMaintenanceDisableOptimize preference to true.

### Print Log Results

Click Print to send all results currently displaying to the printer.
**Manually Fix Errors:** Some errors detected during a check must be fixed manually. If the results log indicates a manual fix is needed, double click on the row to open more details.

This window is non-modal. It can remain open while you access other areas to fix the issue. Close the main Database Maintenance window, then proceed. Click Print to print the results. See [Manually Fix DBM Errors](#) for a list of errors and how to fix them.

**Hidden Tab**
Each database maintenance method can be hidden so it no longer shows in the list of Database Methods. This can be useful for methods your office doesn’t use. Hidden methods show in the Hidden tab.

To hide a method, on the main Database Maintenance window, right click on a method and select *Hide*.

To unhide a method, right click on the method and select *Unhide*.

**Old Tab**
Database maintenance methods that are no longer needed or outdated are moved to the Old tab. Method can still be ran from this window, but only do so if instructed by Open Dental HQ as they can be unnecessary and time consuming.
- Highlight the methods to perform or click **None** to deselect all methods. When no methods are selected, all database methods will run.
- Click **Check** to only run database checks and display results.
- Click **Fix** to run database checks and fix any errors that do not require a manual fix. Some changes made by the Database Maintenance tool are logged in the `dbmlog` table.
- Click **Stop DBM** to stop the next method check/fix. The current method check/fix will finish.
- **Breakdown**: If an X shows in the Breakdown column, double click to see a breakdown of results.

**Tools Tab**
Each database maintenance tool addresses a specific issue. Before running a tool, read instructions carefully. Typically they take a long time to run but only need to be run once.
**Update in progress on computer:** Manually clear the Update in Progress preference. This should be used when an update is complete but workstations are not able to log in due to "update in progress" error.

**Ins Pay Fix:** This tool will fix insurance payments that have been received but not finalized (attached to insurance checks/payments). One check will be created for each claim. The claim payment date will be the date the claim was received.

**Optimize:** This tool will backup, optimize, and repair SQL commands on each individual table. Only use if corruption is suspected or for extremely large databases.

**Appt Procs:** This tool will fix procedure descriptions on appointments that are not correctly showing tooth numbers for some reason. It will also update procedure code text colors and previous date information for existing appointments, if you have Proc Appt Colors(626) for the appointment box.

**Spec Char:** Only use this tool if you are having trouble syncing your appointments to the Mobile Synch App or if you receive an invalid character error while using the Middle Tier. It will permanently remove unsupported Unicode characters from appointment notes, procedure descriptions, patient address notes, patient address fields, adjustment notes, payment notes, and definition names. This will also remove characters from non-English languages. If you wish to continue, the password is fix without quotes.
**InnoDB**: This tool will convert all tables in the database to the selected storage engine (MyISAM or InnoDB). All users are initially set up as MyISAM. Users only switch to InnoDB if they have special needs, such as increased performance. User must have done research on MySQL website.

**Tokens**: This tool will check the database for any X-Charge tokens that are attached to the wrong credit card number. A second window will come up listing all credit cards and letting you decide which ones to check.

**Remove Nulls**: This tool will remove extra, hidden characters that may be causing errors or problems and replace with empty strings.

**Etrans**: This tool will clear etrans messages (electronic transactions) older than one year. An automatic backup will be created first. It can only be run by users with the **Security Admin** permission.

**Active TPs**: This tool will create active treatments plans for patients that have treatment planned procedures but no active treatment plan. This was a known issue in early beta versions of 15.4.

**Raw Emails**: This tool can be useful if you are using the Email Inbox and backup size has grown too large. Large size is often due to the *emailmessage* table. Run the tool to look through all inbound emails, safely remove raw message content that is no longer needed, then optimize the *emailmessage* table.

**Email Attaches**: This tool will rename and move email attachments that are in the base EmailAttachments folder into the intended location in the In and Out subfolders. Resolves file not found errors when trying to view attachments.

**Recalc Estimates**: This tool will identify patients with at least one estimate that belongs to a dropped insurance plan. For each such patient, estimates will be recalculated using their current plan information and will delete estimates associated with dropped plans.

**Pay Plan Payments**: This tool will detach patient payments that have been applied to **Insurance Payment Plans** (258), and insurance payments attached to **Patient Payment Plans** (239).

**Balance Families**: Running this tool requires a password known only by the Open Dental **Conversions Team**. This tool will create a series on income transfers between patients in the same family to correct situations where some family members have a credit and others have a balance due. It may take a long time to complete and impact performance for Open Dental users on other workstations. Contact **Support** for assistance if you are unsure if this is needed for your database.

**Troubleshooting**

Why do I get the message: Log not saved to Repairlog.txt because the user does not have permission to access that file.

IT needs to grant the user permission to the Open Dental folder (typically C:\Program Files (x86)\Open Dental).

Why do I get the message: WARNING! More than 50 workstations are connected to this database. Running DBM may cause severe network slowness. We recommend running this tool when fewer users are connected (possibly after working hours). Continue?

More than 50 workstations are connected to the database. We recommend waiting until after office hours to run Database Maintenance as it can cause slowness.

**Manually Fix DBM Errors**

When you run a **Database Maintenance** (1434) check, some errors need to be fixed manually. These cases are indicated clearly in the log results. Below are examples of results, how to fix errors, and why they may occur. This table has been ommitted.

**Dental Student Evaluations**

In the **Main Menu** (592), click Tools, Evaluations.
Dental Schools(808) student evaluations can only be created by Dental School Instructors(1261). Instructors should also have the Setup permission so they can define the grading scales and evaluation criteria used in evaluations. Users with the Admin Eval Edit permission can view or edit student evaluations, but cannot create them.

To use evaluations:
1. Dental School Grading Scales(899) that will be used for calculation evaluation grades.
2. Set up Evaluations(897) (attach grading scales, define criteria, associate with Dental Course(1233)).
3. Fill out Student Evaluations(1440).
4. Generate Dental Student Reports(1442).

- **Evaluations**: A list of all evaluations created that meet the filter criteria on the right. To edit an evaluation, double click on it.
- **Filter Options**: If you change filter criteria, click Refresh to update.
  - **Date**: Determines which evaluations list. Enter a beginning and end date.
  - **Course**: Filter the evaluations by Dental Course.
  - **Student Filters**: Filter the evaluations by student's last name, first name or ProvNum.
- **Add**: Fill out student evaluations.
- **Reports**: Click to generate dental school reports.

**Fill out Student Evaluations**

In the Main Menu(592), click Tools, Evaluations(1439), On the Evaluations window, click Add.
Only Dental School Instructors (1261) can fill out a student evaluation. Users with the Admin Eval Edit permission can view or edit evaluations. Before filling out an evaluation for a student, you must set up evaluations. See Dental School Evaluation Setup (897).

The list can be filtered by dental course. Double click to select an evaluation.

Enter general evaluation information.
- **Date**: Defaults to today's date, but can be manually changed.
- **Student**: Click [...], then double click the Student (1263) this evaluation is for.
- **Scale, Course, Instructor, Title**: This information cannot be changed from this window.
Enter the student grade information. What shows as criteria is dependent on how the criteria is defined in evaluation setup.

- If a criteria's grading scale is *Pick List*:
  - Click on a criteria row on the left and possible values will show on the right.
  - Click on a value on the right to automatically populate the Showing and Number fields on the left. You can also type the value in the Number cell. Invalid numbers are not saved.
  - Enter any notes by clicking in the Note cell.

- If a criteria's grading scale is *weighted*:
  - Click on a row and the maximum point value will show on the right.
  - Click in the Number cell to enter the student's points.
  - Enter any notes by clicking in the Note cell.

- If grading scale is *percentage*:
  - All percentage criteria are based on 0 - 100.
  - Click in the Number cell to enter the student's percentage.
  - Enter any notes by clicking in the Note cell.

As you enter evaluation numbers, the Overall Grade Number and Overall Grade fields at the bottom will automatically update using the evaluation's Grading Scale (899). To override a overall calculation, enter the value in the blank boxes to the right of each field.

Click **OK** to save.

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### Dental Student Reports

In the **Main Menu** (592), click **Tools, Evaluations** (1439), Reports.

![Evaluation Report](image)

Currently there is only one **Dental Schools** (808) report that generates a list of student evaluation grades by dental course.

Select the **Dental Course(s)** (1233). A list of instructors will show.

Select the **Instructor(s)** (1261). A list of students will show.

Select the **Student(s)** (1263) to report on.

To select multiple courses, instructors, or students, click and drag, press Ctrl while clicking, or select an 'All' option.

Click **OK** to generate the report.
• **Zoom In/Full Page**: View the report at 100% or as a full page.
• **Arrows**: Click the left/right arrow to jump pages in a multi-page report.
• **Query View**: Open the report in the Query(1382) window.
• **Print**: Print the report to the default printer.
• **Export**: Save the report as a txt or xls file.
• **Close**: Close the report window.

**Kiosk**

The kiosk is a secure method for patients to fill out forms.

In the **MainMenu**(592), click Tools, Kiosk.
Alternatively, in Patient Forms(1690), click Kiosk.

If the Kiosk was launched from the Main Menu, then this will be a dedicated Kiosk computer. The patient forms will be loaded into the Kiosk from the Kiosk Manager(1444).

When the Kiosk is launched, the first form (Kiosk order of 1) will show. The kiosk takes up the entire screen, so patients have no access to any other programs on the computer, including Windows features such as task bars.

Pale yellow areas indicate where the patient should enter information. Free form drawing is possible. The Eraser tool can be used to erase drawn items. Patient's can sign in signature boxes using a mouse or a touch screen with stylus.

To close one form and move to the next, patient will click OK. When the last form is completed or user clicks Cancel, this screen will show.

![Forms - Double click to edit](image)

To edit or revise a form, double-click to reopen.

When forms are complete, patient will click Done. If the Kiosk was launched from the Main Menu, the forms will disappear, but the kiosk will remain active. If, instead, the Kiosk was launched from the Patient Forms window, then it will return to that window.

**Tablets**
The kiosk feature can be used on tablets running a full version of Windows.

To use an iPad or Android tablet, see eClipboard instead.

To determine the best option for your office, see Tablet.

**Kiosk Manager**
The Kiosk Manager is used to load patient forms for the kiosk.

In the MainMenu(592), click Tools, Kiosk Manager.
The Kiosk (1443) allows patients to fill out forms at a computer in the dental office, such as in the reception area or in an operatory. You can setup a workstation that is used as a kiosk only, or run the kiosk on a computer that is also used for other purposes.

Use the Kiosk Manager to remotely load patient forms to kiosks on separate workstations. For example, activate a kiosk in your reception area. Then from the receptionist's desk, run the Kiosk Manager to remotely load patient forms to the reception area kiosk. The Kiosk Manager can be run on multiple computers and remain open while you use Open Dental. On each computer where the patients will fill out forms, click Tools, Kiosk to activate the Kiosk.

**Load Patient**

On the computer that is running the Kiosk Manager, select the patient (e.g. click on their appointment).

Click **Add or Remove Forms** to launch the Patient Forms (1690) window. Click Add, select a form, then click **To Kiosk**. Repeat for each form. The order the forms will present to the patient is determined by the Kiosk Order number.

In the Kiosk Manager, the current patient name and selected forms will show on the right.

From the list of Active Kiosks in this window, click **Load** in the Action column of the desired kiosk. After a few moments, the patient will see the first form in the Kiosk (1443) window on their computer.

**Note:** If accessing kiosks using Remote Desktop Protocol or Citrix, each kiosk is identifiable by computer and session name. If you launch Kiosk from the same connection twice, you may be asked to enter a unique identifiable name.

When the patient completes the forms and clicks Done, their kiosk will clear and the patient will no longer show as active in the Kiosk Manager.

To remove a computer from the Active Kiosk list, when it is clear that a kiosk is not actually running on that computer, click **Delete**. If a kiosk is running on a device when it is deleted from the list, kiosk mode will be closed.

If you accidentally load the wrong patient, click **Clear** in the Action column on that specific device.

**Security**

Set and save a password that will be required to close the kiosk on a workstation. This will prevent patients from accessing other data. The kiosk takes up the entire screen, so patients have no access to any other programs on the computer, including Windows features such as task bars. There is a hidden close button at the lower right corner of the kiosk window that the patient is using.
If a password has been set, it will ask for the password.

If the Kiosk was launched from the Main Menu, it will also cause Open Dental to close.

If the Kiosk was launched from Patient Forms, it will not close Open Dental.

While the patient is filling out forms, no staff member will have access to the patient's Edit Patient Information window.

**Software and Hardware**
To have patients fill out forms online, see [Web Forms Feature](#).

[Computer Requirements](#) are the same as any other computer running Open Dental.

Before using tablets as a kiosk device, see [Tablet](#).

See [Patient Registration Vendors](#) for vendors that offer applications that work with the Kiosk.

**Language Translation**
Open Dental's translation tool is a way to enter translations on your own.

In the [Main Menu](#), click Tools, Language Translation.
See International Customers.

Note: This menu item is only visible if the computer's Region and Languages setting is set to a foreign language.

Language support is built into Open Dental. The code is written to automatically adapt to the user's Region and Language Settings. Translations are specific to the culture (country), not just the language. For example, there are many Spanish translations available depending on which country you are in. If a translation has not been made specifically for your country, the code will use a translation for the same language from a different country.

Set your computer's Region and Language Settings to your language/country, then restart Open Dental for changes to take affect.

**Download:** Download and install current available translations. See below for a list of available translations.

**Export All:** Export custom language settings to share with other users.

All translated words and phrases are organized by category. The category usually corresponds to the name of window each item is displayed in. To understand the various categories and windows, you will need to become familiar with the program. As you access areas in Open Dental, English phrases are dynamically added to the translation tool. The more you use the program, the more categories will show, and the more phrases will be available to translate. The program is designed this way to help you more easily identify and translate the areas of the program that you actually use.

Double-click on a category to enter custom translations.
This window shows all the available phrases and translations for a category. The more you work with the program, the more phrases that will appear.

Double-click on an item to edit.

**English:** You cannot add English comments; it is only for our use.
Translation: Enter the translation. If a phrase needs to be left blank, enter a space. (e.g. for Social Security Number). A space is very different from an empty field. A space will make the word show up empty; an empty field will retain the English version.

Other Translation: Will show any other available translations for your language. For instance, if you are translating for Spanish Peru, you may see an existing translation for Spanish Mexico or Spanish Puerto Rico.

Comments: Enter any comments.

Custom Fields
Some fields in Open Dental are not accessible via the translation tool because they are easily customizable for all users. Refer to many of the options in the Main Menu, Setup.

- **Display Fields**: Define which fields appear in various Open Dental windows (e.g. patient information, procedure information). Enter translations as field descriptions.
- **Patient Fields**: Create and translate custom patient fields that will show in the Patient Information area of the Family module.
- **Appointment FieldDefs**: Create and translate custom Appointment fields that show on the Edit Appointment window, and can be displayed in an Appointment View.
- **Definitions**: Define and translate category/list options that are used throughout the program.
- **Operators**: Define operator names.
- **Procedure Codes**: Setup procedure codes and translate descriptions and notes.
- **Setup Recall** and **Confirmation Setup**: Translate recall and confirmation messages.
- **Auto Notes**
- **Fee Schedules**
- **Insurance Categories**
- **Messaging**
- **Module Preferences**

Available Translations
The following translations are available to download:
- Spanish-Mexico: es-MX.txt
- Italian: it-IT.txt
- Germany-German: de-DE.txt
- Netherlands-Dutch: nl-NL.txt
- French-Canadian: fr-CA.txt

Mobile Synch Setup
When using the Mobile Synch Feature application, data must be uploaded to Open Dental's server. It will then continue to synch with your database server to ensure content is up-to-date. The synch will start when you launch Open Dental, after the database is selected but before user login.

1. Open the Mobile Synch (old-style) tab.
   - In the **Main Menu** (592), click Tools, Mobile Synch, or click eServices, Mobile Sync.
   - In version 16.3 and greater, the tab is hidden if Mobile Synch has not been used recently. To find the tab, click Show Mobile Synch (old-style) on the eServices Misc (1634).
2. Enter the server and upload preferences:
   - **Host Server Address**: No need to change this. This is the Open Dental server where data will be sent during synchronization.
   - **Minutes Between Synch**: The interval, in minutes, between automatic synchronization of Open Dental's server and your database. 10 minutes is a good setting to start with. If synching is too frequent, the workstation may lock momentarily while synching. A longer interval minimizes the problem.
   - **Exclude Appointments Before**: Enter a date, or leave it blank to include all appointments. A date can reduce the amount of time it takes for the initial synch.
   - **Workstation for Synching**: Identify the one workstation in the office that will synch with Open Dental's server.
   - **User Name**: Must be at least 10 characters long and complicated (upper and lower case letters, at least one number, and one special character). For technical reasons, certain symbols do not work and will result in a failed login attempt on the mobile device. Specifically, we are aware that the &, +, and sometimes the % symbols cannot be part of the username. You can choose to 'remember' the user name on your mobile device so you don’t always have to reenter it.
   - **Password**: Can be short and simple. It protects viewing of your data by anyone else on your mobile device.
   - **Synch Troubleshooting Mode**: Mobile Synch runs much slower in this mode. When checked, data will synch one patient at a time instead of in a batch. This is designed so when a synch is failing, you may find the patient or record that is causing the failure and correct it.

3. Click Synch to upload.

Other options:

**Delete All**: Deletes all data from the Open Dental server.

**Full Synch**: Delete all data from the Open Dental server then upload fresh data. This should only need to be done once.

**Synch**: A synch can be forced at any time in addition to the automatic timed synch.

---

**Using Mobile Synch**

Before using the [Mobile Synch](1449) app, you must contact Open Dental to enable, then upload and synch data.
Log In
Type https://m.opndn.com into your mobile browser. Don't forget the s in https. Save it as a favorite.

Open Dental

For a demo, use the User name: demo

User name
triCKv8%d

Password

☐ Remember username

Login

Type in the User name and Password that you set previously. Click Login.
<table>
<thead>
<tr>
<th>Time</th>
<th>Name</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>09:00 AM</td>
<td>Bailey, Kevin</td>
<td>Pro In pain</td>
</tr>
<tr>
<td>09:30 AM</td>
<td>Abbot, Bejamin</td>
<td>2-BWX Running late</td>
</tr>
<tr>
<td>11:10 AM</td>
<td>Adams, Mike R.</td>
<td>Pano may be late</td>
</tr>
<tr>
<td>01:00 PM</td>
<td>Stump, Anna B.</td>
<td>Flo, Ex, Pro Moved from last month</td>
</tr>
<tr>
<td>04:00 PM</td>
<td>Roberts, 'Barb' Barbara</td>
<td>Flo, Ex, Pro In pain</td>
</tr>
</tbody>
</table>
Patient Detail
Includes entire Appointment and Rx history. You can search for patients by last name only.
There are other screens that are not shown.

**Other Mobile Solutions**

**Mobile Web Feature**

Use Remote Access software to remotely connect to an office computer from the mobile device. Some scrolling will be required to see the different parts of the office screen.

**Dashboard Setup**

Patient Dashboards can be created and edited as needed.

In the Main Menu (592), click Tools, Patient Dashboards, Dashboard Setup.
Alternatively, if a database has more than 28 dashboards, in the Main Menu, click Tools, Patient Dashboards, Setup.

Also see Patient Dashboard(1507).

**User Group**: For a user to be allowed to access to a dashboard, they must be assigned to a user group that has a dashboard marked as Allowed. The Security/Admin permission is required to allow user group access.

**Set All**: Click to mark all custom dashboards as allowed for the selected user group.

**Internal**: Lists the original sheet template that comes with Open Dental. This sheet cannot be edited, but can be copied.

**Custom**: Lists customized templates that have been created by your office.

**Allowed**: Select each dashboard that you wish the selected user group to have access to. Allowed dashboards will be marked with an X.

**Copy**: Click to copy the internal sheet to be customized.

**Tools**: Click to Import or Export a patient dashboard sheet. Useful for sharing saved layouts with other Open Dental databases.

**Editing a Dashboard**

Double-click a dashboard in the Custom column to edit it.

Dashboards are edited in the same style as sheets. For more information on editing sheets, see Sheet Field Types(1130).
Public Health Screening

In the Main Menu(592), click Tools, Public Health Screening.

Use the public health screening tool to add screening groups, set permissions, and enter screening information. Public Health(71) must be turned on.

General Steps:
1. In Chart Module Preferences(706), set whether screenings use custom screening forms (sheets) or the classic form.
2. Add Screening Groups and Set Screening Permissions (see below).
3. Screen Patients:
   - Public Health Classic Screening(1459)
   - Public Health Custom Screening(1462)

Screening groups already set up for the selected date range will list. If you change the date range, click Refresh to update the list:
- Click Today to insert today's date.
- Click left or right arrow to move back or forward one day.
- Enter a custom date range in the From/To fields.

Add screening groups
Typically a screening group is a classroom of children, but it can be as large as an entire school. Each group has the same date, screener, and location. If you revisit the same school later, it is considered a separate group because it will have a different date.

1. On the Edit Screening Group window, click Add to add a group, or double click an existing group to edit.
2. Enter general information about the screening group.
   - **Date**: The date the screening is taking place.
   - **Description**: A description of the screening group.
   - **Screener**: The screener name. If you select a provider this field will automatically populate.
   - **Or Prov**: If a Provider is doing the screening, select their name.
   - **County**: The County where the screening is occurring.
   - **School**: The Site of the screening.
   - **Location**: The place of service.

3. Add the patients to be screened.
   1. Click **Add** to open the Select Patient window. See **Select Patient** (1649).
   2. Select the patient and click **OK**.

   As patients are added, their name will show in the Patients for Screening grid with a permission status of **unknown**.

3. (optional) If using a custom screening form, click the **Sheet** dropdown to select the form for this screening. The default is the internal sheet. The form can also be selected at the time of the screening. Once selected, the setting is saved with the screening group.

   - **Note**: Double click a patient to open the **Edit Patient Information** (62).

   - If needed, patients can be added via the Select Patient window.

   - To remove a patient, highlight then click **Remove**.

   - **Anonymous Screenings**: Usually each person screened will have a patient record in Open Dental and permission to be screened. If there is no patient record, or a patient doesn't have permission, you can enter an anonymous screening. Simply click **Add Anonymous** at the bottom of the Edit Screening Group window.

**Set screening permissions**

Only patients with a screening permission of **Allowed** will be screened. Right click on a patient then select their permission level.
The options are Unknown, Allowed, No Permission, Refused, Absent, Behavior, and Other.

**Public Health Classic Screening**

In the [Main Menu](592), click Tools, [Public Health Screening](1457).

These steps explain how to use the classic public health(71) screening form.
- In [Chart Module Preferences](706), uncheck Screening Use Sheets to use the classic form.
- Before patients can be screened, set up screening groups and add patients. See [Public Health Screening](1457).

Double click the screening group to select it. Screening groups are grouped by date. If needed, change the date and click Refresh.
Patients should already list under Patients for Screening.

- Only patients with *Allowed* permission will be screened. Change permissions if needed by right clicking on a patient.
- To change patient information, double click a patient then enter on the Edit Patient Information (62).
- Anonymous screenings do not require adding a patient or setting screening permissions. See Anonymous Screenings at the bottom of this page.

Click Screen Patients. The classic screening form for the first patient with an *Allowed* permission that hasn't been screened yet will open.
Row: Determines the sort order of the screening in the list of screenings. Automatically uses the next row in the sequence.
Name: Cannot be changed from here.

**Grade level, age, birthdate:** Automatically populates if information is already entered on the Edit Patient Information window. Change if needed.

Charting Options: Check a box to select it. Each option has three available states: blank, checked, or unknown. You only need to enter information that is required by your organization.

**Race ethnicity, gender, urgency:** Automatically populates if information is already entered on the Edit Patient Information window. Change if needed.

Click OK to save. A new row will show in the Screenings list for this patient.

If there are more patients to screen, a new screening form will open for the next patient who has an *Allowed* permission and hasn't been screened. The new patient's information will be auto-filled if known. If not known, the information from the previous screened patient is automatically used.

- Note: To exit screenings, click **Cancel** on the screening form. To resume, click **Screen Patients** again.
- If you delete a screening for a patient, their permission level returns to unknown.

**Add Anonymous Screenings**
Anonymous screenings do not require adding a patient or setting screening permissions.

1. Click **Add Anonymous**.
2. Enter the information. All information except Name can be entered.
3. Click OK, a new screening form will open, filled in with information from the previous individual.
4. When finished click Cancel.

If the person needs treatment, consider entering them into the system as a regular patient (if not already entered) and putting their patient ID number in the Comments section.

**Public Health Custom Screening**

In the [Main Menu](592), click **Tools, Public Health Screening** (1457).

These steps explain how to use a custom public health screening form.

- In [Chart Module Preferences](706), check **Screening Use Sheets** to use the custom form. To customize the sheet, see [Screening Layout](1176).
- Before patients can be screened, set up screening groups and add patients.

Double-click the screening group to select it. Screening groups are grouped by date. If needed, change the date and click **Refresh**.
Patients should already list under **Patients for Screening**.

- Only patients with *Allowed* permission will be screened. Change permissions by right clicking on a patient.
- To change patient information, double-click a patient to open the [Edit Patient Information](1457).
- To add patients, see [Public Health Screening](1457).
- Anonymous screenings do not require adding a patient or setting screening permissions. See Anonymous Screenings at the bottom of this page.

If needed, click the **Sheet** dropdown to select the screening form to use. The default is the internal screening sheet. Once you select a form, it is saved with the screening group.

Click **Screen Patients**. The screening form for the first patient with an *Allowed* permission, who hasn't been screened yet, will open.

Enter screening information. See below for a description of common form elements.

Click OK to save. A new row will show in the Screenings list for this patient and a Screening Form will list in the patient's Chart Module, Progress Notes.

If there are more patients to screen, a new custom form will open for the next patient who has an *Allowed* permission and hasn't been screened.

- **Note**: To exit screenings, click Cancel on the screening form. To resume, click Screen Patients again.
- If you delete a screening for a patient, their permission level returns to 'unknown'.

### Elements in a custom screening form

The options below show in the internal screening form. If you have customized a custom screening form, your options may vary.

Pale yellow fields indicate areas where you can type new or changed information. Names, birthdate, age, and preferred name will be pre-filled if the information is entered on the Edit Patient Information window.

<table>
<thead>
<tr>
<th>Last Name: Andrews</th>
<th>First Name: Jonathon</th>
<th>Middle:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender: Male</td>
<td>Birthdate: 02/02/2008</td>
<td>Age: 8</td>
</tr>
<tr>
<td>Description: 3rd Grade</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Screener: Johnson, Liz</td>
<td></td>
<td></td>
</tr>
<tr>
<td>County: Marion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date of Screening: 03/09/2016</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Place of Service: MobileUnit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgency: Unknown</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Race / Ethnicity: Unknown</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grade Level: Third</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preferred: Jonny</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Combo boxes: These are pick lists from which you can select from a list of options. Click the combo box, then click an option. Gender, place of service, urgency, and grade level will be pre-filled if the information is entered on the Edit Patient Information window.
Checkboxes: Checking the following boxes automatically adds a corresponding completed procedure code to the patient's chart. Additional checkboxes can be added to a custom screening sheet.

- **Assessment Proc**: Adds procedure code D0191 (assessment of a patient).
- **Fluoride Proc**: Adds procedure code D1206 (topical application of fluoride varnish).

![Checkbox images]

Tooth Charts: Tooth charts can be used to mark tooth status. Primary or permanent teeth is set when customizing the screening form. There are two chart options:

- **Screening Chart**: Mark current tooth status including treatment needed.
- **Sealant Placement**: Mark completed sealant procedures.

Click on a tooth or surface in the chart then select a code to mark it. Teeth 2, 3, 14, 15, 31, 30, 19, and 18 allow a code per surface. You can mark a single surface or all. A legend of the codes shows under the Screening Chart.

- **S** = Seal
- **PS** = Previously Sealed/Intact
- **C** = Caries
- **F** = Filled
- **NFE** = Not Fully Erupted
- **NN** = Not Needed
- **None** = remove a previously marked code.

Sealant Procedures on Permanent Teeth: If S is marked on a tooth or surface, a corresponding procedure (D1351) is also automatically added to the patient's chart. If marked on the Screening Chart, the sealant procedure will have a TP status. If marked on the Sealant Placement chart, the sealant procedure will have a C status (complete). Surface information will be associated with the procedure, but not sent with claims. Sealants are the only code that will insert a procedure in the chart. All other codes are informational only but are reportable in custom queries.

<table>
<thead>
<tr>
<th>Date</th>
<th>Th</th>
<th>Surf</th>
<th>Description</th>
<th>Stat</th>
<th>Prov</th>
<th>Amount</th>
<th>ADA Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>03/11/2016</td>
<td>2</td>
<td>MDL</td>
<td>sealant - per tooth</td>
<td>C</td>
<td>DOC Albert</td>
<td>67.00</td>
<td>D1351</td>
</tr>
</tbody>
</table>

Screening Chart Example: S indicates teeth or surfaces where a sealant is treatment planned. C indicates caries. NFE indicates a tooth not yet erupted. For each permanent tooth with a S code, a corresponding sealant procedure will be added to the patient's chart with a treatment planned status.
Sealant Placement Example: Each S indicates where a sealant procedure was completed. For each permanent tooth with a S code, a corresponding sealant procedure will be added to the patient's chart with a completed status.

Add anonymous screenings
Anonymous screenings do not require adding a patient or setting screening permissions.
1. Click **Add Anonymous**.
2. Enter the information. All information except Name can be entered.
3. Click OK. A new screening form will open.
4. When finished click Cancel.

If the person needs treatment, consider entering them into the system as a regular patient (if not already entered) and putting their patient ID number in the Comments section.

Repeating Charges
Use the Repeating Charges tool or set up automated repeating charges to post repeating procedures to patient accounts each month.

In the **Main Menu**(592), click Tools, Repeating Charges.

To set up repeating procedures for a patient, see **Repeating Charge**(262).

Repeating Charges Tool
The repeating charge tool will complete any repeating procedures set up for a patient, create a primary and secondary insurance claim for the procedure (if enabled), and allocate any prepayments (if enabled). Run this tool before generating the **Billing List**(507) to include repeating charges on patient statements and before running the recurring charges tool to include these patients with new balances.
To run the tool:
1. In the main menu, click Tools, Repeating Charges.
2. **Run aging on accounts after posting charges:** Check to run Aging (1423) and update the age of account balances for patients with the new charges.
3. Click OK. The total number of procedures and claims added will show.

- **Note:** If the tool is run after the scheduled repeating charge day (up to 1 month and 20 days after), it will backdate all missed repeating charges to the patient's account with the date of the scheduled charge.
- An Audit Trail (1424) entry is made each time Repeating Charges is run.

### Automated Repeating Charges
Optionally, enable the automated repeating charge preference to automatically post repeating procedures at a specific time each day instead of manually running the tool. The automated service will also create primary and secondary insurance claims for posted procedures (if enabled), and allocate any prepayments (if enabled). To enable the service, in the Account Module Preferences (693), Misc Account tab, check Repeating charges run automatically and set the daily run time. Set the time to run prior to generating the billing list and at least 30 minutes to an hour before the automated CC Recurring Charges (1430) run time (if enabled). This is to include repeating procedures on statements and in credit card charges. Also, ensure the computer with the OpenDentalService (1412) (typically the server) is on at the scheduled run time. Open Dental does not need to be running but the computer must be on for the service to work.

Once enabled, repeating charges will only post once per day and will not run if the service or the repeating charge tool has been run, is currently running, or if the recurring charge tool is running. If the repeating charge run time is changed, the service will not run again until the next day. The repeating charge tool may be safely run at any time to post new repeating charges that are set up after the automated preference has been run.

Example of transactions when a prepayment is applied to a repeating charge using an income transfer.

<table>
<thead>
<tr>
<th>Date</th>
<th>Patient</th>
<th>Prov</th>
<th>Code</th>
<th>Tih</th>
<th>Description</th>
<th>Charges</th>
<th>Credits</th>
<th>Balance</th>
</tr>
</thead>
<tbody>
<tr>
<td>09/26/2018</td>
<td>John</td>
<td>Pay</td>
<td></td>
<td></td>
<td>Credit Card $1,500.00 - Prepayment</td>
<td></td>
<td></td>
<td>-1,500.00</td>
</tr>
<tr>
<td>10/01/2018</td>
<td>John</td>
<td>DOC A</td>
<td>D8060</td>
<td>Txfr</td>
<td>interceptive orthodontic treatment of the transitional dentition</td>
<td>125.00</td>
<td></td>
<td>-1,375.00</td>
</tr>
<tr>
<td>10/01/2018</td>
<td>John</td>
<td>DOC A</td>
<td></td>
<td></td>
<td>Allocated $125.00 prepayments to repeating charge.</td>
<td>0.00</td>
<td></td>
<td>-1,375.00</td>
</tr>
</tbody>
</table>

Example of transactions when a claim is created automatically for a repeating charge.

<table>
<thead>
<tr>
<th>Date</th>
<th>Patient</th>
<th>Prov</th>
<th>Code</th>
<th>Tih</th>
<th>Description</th>
<th>Charges</th>
<th>Credits</th>
<th>Balance</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/01/2018</td>
<td>John</td>
<td>DOC A</td>
<td>D8060</td>
<td></td>
<td>interceptive orthodontic treatment of the transitional dentition</td>
<td>125.00</td>
<td></td>
<td>125.00</td>
</tr>
<tr>
<td>10/01/2018</td>
<td>John</td>
<td>DOC A</td>
<td></td>
<td>Claim</td>
<td>Sec Claim $125.00 Alpha Dental Hold until Fri received</td>
<td></td>
<td>125.00</td>
<td>125.00</td>
</tr>
<tr>
<td>10/01/2018</td>
<td>John</td>
<td>DOC A</td>
<td></td>
<td>Claim</td>
<td>Pri Claim $125.00 Premiere Dental Waiting to Send Estimated Payment Pending:</td>
<td></td>
<td></td>
<td>37.50</td>
</tr>
</tbody>
</table>

### Troubleshooting
If you attempt to run the repeating charges tool and get the message below, this indicates repeating charges are still in progress.
Once repeating charges have started, whether by the tool or automated service, a flag with the start date and time is set to prevent other users from running the tool again. When complete, the flag is cleared. If, after 24 hours, you continue to get this message or notice repeating charges have not posted, try clearing the flag manually. Have a user with the **Security Admin** permission log in and re-run the repeating charges tool.

The security admin is prompted to restart repeating charges.

Click OK. The flag will reset and the repeating charge tool will restart. If successful, a message box will appear with the total number of repeating procedures posted.

**Setup Wizard**

Use the Setup Wizard tool to begin initial setup of your Open Dental database and track progress.

In the **Main Menu**(592), click Tools, Setup Wizard.
Green rows indicate areas where information has been entered. Red rows indicate areas that still require input. To read a brief explanation of a setup area, click the information icon (i).

To run through the entire setup wizard, click Set Up All. To begin setup of a category, double click the category (Pre-Setup, Basic Setup). To only access a specific item, double click a row.

Follow the instructions on each window to enter information, then click a button to proceed.
- **Back**: Return to the previous window.
- **Next**: Proceed to the next window.
- **Skip**: Leave the current setup area without entering information.
- **Close**: Exit the setup wizard.

Below is a list of the information that can be entered via the Setup Wizard.
- Registration Key
- Basic Features
- Providers
- Employees
- Fee Schedules
- Clinics
- Operatories
- Practice/Headquarters Information
- Printers/Scanners

A welcome window will preview each setup area. A completion window will indicate when the setup information has been entered. Below is an example of the welcome window that previews the Registration Key Setup area.
Registration Key Setup
Enter the Open Dental registration key and run Procedure Code Tools.

Registration Key
1. Click Change.
2. Enter the unique registration key for the practice.
3. Read the CDT licensing agreement as needed.
4. Check I agree to the terms of the above license agreement in its entirety.
5. Click OK to save.

Procedure Code Tools: This tool updates the procedure codes used in Open Dental.
1. Click Procedure Code Tools.
2. Check the boxes of the tools to run. By default, only the D Codes box is checked. This tool adds missing CDT codes to the Procedure Code List.
3. Click Run Now.
4. Messages will indicate when the tool has finished running. Click OK to close.
5. Click Close to close the window.

To access advanced update setup information, click Advanced in the lower right.
Basic Feature Setup
Quickly turn on/off basic features your office may or may not use. Settings will affect all computers using the same database.

- To read a brief explanation of a feature, click the information icon (i).
- To turn a feature on, check the box. To turn a feature off, uncheck the box.
- Only basic settings are listed. To view all available features, click Advanced in the lower right to open the Show Features window.
Provider Setup
Enter information about providers. At a minimum enter abbreviation, first and last name, suffix, SSN or TIN (for dentists), and NPI.

- All current providers will list. Red cells indicate missing information.
- To add a provider, click Add. To edit provider information, double click a row. See Provider(1255) for field definitions.
- For more options (e.g. reassign and move providers, and reorder the provider list), click Advanced in the lower right to open the main Providers window.
**Employee Setup**

Enter employee names and payroll IDs (optional). This information is used to create user security profiles, set up employee work schedules, and provide access to the time clock.

- All current employees will list. Red cells indicate missing information. First and last name are required.
- Click Add to create a new employee. To edit an existing employee, double click the row. See Employees(1233) for field definitions.
- Click Advanced in the lower right to open the main Employee List window.
Fee Schedules
Enter office and insurance fee schedules. These will be assigned to a patient's insurance plan to accurately reflect treatment estimates.

- All current fee schedules will list.
- Click Add to create a new fee schedule.
- Click Edit Fees to bring up Procedure Codes to edit the associated fees.
- Click Import to import fees over the currently selected fee schedule. File must be in tab-delimited format (.xls, .txt, or .csv) with a column for procedure code and column for fees.
Clinics Setup
If you turned on Clinics in Basic Feature setup, enter basic information about each clinic.

- All current clinics will list. Red cells indicate missing information. Description, abbreviation, phone number, and address are required.
- Click Add to create a new clinic. To edit an existing clinic, double click the row.
- Click Advanced in the lower right to open the main Clinics window.

Note: Enter headquarters information in Practice Setup.
Operatory Setup

Name operatories that will show in the appointment schedule, assign default providers and clinics, and designate specific hygiene operatories.

- All operatories currently set up will list. Red cells indicate missing information. Name and abbreviation are required.
- Click Add to create a new operatory. To edit an existing operatory, double click the row. See Operatory Setup(628) for field definitions.
- Click Advanced in the lower right to open the main Operatories window.
Practice Info Setup
Enter general contact information, billing and pay-to addresses, and default providers for the practice. If Clinics is turned on, practice refers to headquarters.

- **Practice Title**: The name of the practice. If there is only one provider, the practice title can be the name of the provider.
- **Phone / Fax**
- **Physical Treating Address**: The physical location where treatment is performed. This address is always used on statements.

To enter additional practice information, click Advanced in the lower right.
Printer / Scanner Setup

Set up print and scan options for the current workstation.

**Printer Setup**: All categories that allow you to set a default printer are listed. See [Printer Setup](601) for more details about each option.
- For each category, click the dropdown to select the default printer.
- **Prompt**: Check the box to show a prompt window every time you print. This allows you to verify printer and select other options prior to printing. When unchecked, items are printed directly.
- **Show me the simple interface**: To only set one default printer for all categories, check ‘Show me the simple interface’, then select the printer.

**Scanner Setup**: Set default options when scanning in the Images module. Click the information (i) icon for more details about an option.
- **Show Select Scanner Window**: Prompt user to select a scanner each time they scan.
- **JPEG Compression - Quality After Scanning**: Set the image quality (0 – 100) for the scanned file. A lower number means more compression and smaller file size.
- **Show Scanner Options Window**: Prompt the user to select scanning options each time they scan.
- **Use the Options Below**: Use the default scanning options set below each time a user scans.
  - **Multipage Scans Duplex**: Checked: Scan both sides of documents. Unchecked: Scan one side of documents.
  - **Grayscale**: Checked: Scan in grayscale. Unchecked: Scan in 24-bit color.
  - **Resolution**: Enter the document resolution in dots per inch (50 - 1000).

Click Advanced in the lower right to select additional Radiograph and Suni Imaging settings.
Dental School Requirements Needed
In the **Main Menu** (592), click Setup, Requirements, Needed.
This is a feature for Dental Schools (808). Requirements can be added and copied to class/course combinations, attached to appointments, then managed by students and instructors.

**Add Requirements**
Select the Class and Course.

Click Add.

Enter the requirement, then click OK.
Repeat for all requirements for the class/course combination.

**Copy Requirements**
Requirements for one class/course combination can be copied to another. Existing requirements will not be replaced.
1. Select the class and course to copy from.
2. Select the class and course to copy requirements to.
3. Click Copy Requirements. A confirmation message will show. Click OK to copy.

**Attach Requirements to an Appointment**
A requirement can be added multiple times to an appointment, and requirements for multiple students can be added to one appointment. Students and instructors can add requirements to appointments.
1. In the left panel of the Edit Appointment, click Req.
2. Select class and course.
3. Highlight a student.
4. Highlight the requirements to add, then click Add. They will list under Currently Attached Requirements.

**Students: Viewing and Editing Requirements**
A student can view and edit their requirements when the following conditions are met:

- Student is logged in as a user.
- User must be linked to a provider in the User Edit window.
- The linked provider must be assigned to a class in the Provider (1255).

1. In the main menu, click Tools, Student Requirements.

2. Double-click a requirement to view it or to change a patient or appointment the requirement is attached to.
3. Click Detach to remove a patient or appointment. Click Select to select a different patient.
4. Click OK to close the window and save any changes.

**Instructors: Viewing Requirements**
When the instructor is logged in, they can view student requirements.
1. In the main menu, click Tools, Student Requirements.
2. Select the Class and Course.
3. Double-click on a student to see a list of their requirements.
4. Double-click a requirement to view details.
5. Verify the patient and appointment.
6. Click Cancel to close the window.

Requirements are pass/fail, with no grade assignments.

Wiki
Each office can have their own internal wiki, similar to wikipedia.

In the **Main Menu**, click Tools, Wiki.
The home page will open. Multiple wiki pages can be open at once. A wiki can be useful for posting employee policies, sharing troubleshooting information, keeping lists, etc. Blue text indicates a link to another page, folder, file or URL.

Wiki pages are displayed in html in a browser control inside of Open Dental. Pages are not stored internally as html; they are only processed from Wiki Markup to html as they are displayed. Users only edit the wiki markup, and have no direct control over the actual html results. This results in consistent pages and fast editing. An instant preview lets users see changes as they are made.

Data is stored in the Open Dental database. Images are stored in the A to Z Folder in the wiki subfolder.

Related Links:
- Wiki Edit
- Wiki List
- Wiki Markup

Toolbar
- Back: Move back one wiki page.
- Fwd: Move forward one wiki page.
- Setup: Customize the html master page and embedded stylesheet. Enable wiki link preferences.
  - Detect wiki links in textboxes and grids: If checked, wiki links can be right clicked and opened from textboxes and grids, e.g. from Tasks. To create a wiki link in a task, use double brackets around the page title: [[Example Wiki Link]].
  - Allow new wiki pages from links: If checked, wiki pages that do not exist can be created when following a link from textboxes and grids. If unchecked, when a link for a wiki page that does not exist is right clicked, a warning will pop up that the page does not exist.
- Home: Jump to the wiki home page. Click the dropdown to save the current page as the home page.
• **Edit**: Edit the current wiki page.
• **Print**: Print the current wiki page.
• **Rename**: Rename the current wiki page. Page names determine the text that displays in the search. When you rename a page, all links to that page are automatically updated.
• **Archive**: Archive the current wiki page, removing it from the Search. Archived files can still be accessed (and restored) via the Search by checking Archived Only.
• **History**: View a complete dated archive of all previous versions of the current page. You can revert to a previous version by highlighting the version in the Page History window and clicking the Revert button on the right side of the screen.
• **Drafts**: View a list of saved drafts for the current page.
• **Incoming Links**: View all pages that are linked to the current page.
• **Add**: Create a new page.
• **Lists**: View, create and edit Wiki Lists.
• **Search**: Search the wiki for specific text.

**Search Results**
Search results are listed in this order:
1. Pages that have matching keywords, listed alphabetically.
2. Pages that have matching characters in the Page Name, listed alphabetically.
3. Pages that have matching characters anywhere in the content, listed alphabetically.

To exclude content from the results, click the **Ignore Content** checkbox.

To only view previously archived pages, click **Archived Only**.

**Troubleshooting**
If you receive an unhandled exception when trying to access a Wiki page (e.g. no ending tag), try following these steps:

1. In the main menu, click Tools, Wiki.
2. Click Search, then select the corrupt page.
3. On the error, click Continue.
4. Click OK.
5. On the error, click Continue.
6. Click Edit and manually fix the page, or click History and revert to a previous version of the page.

**Wiki Edit**
In the Wiki(1484), click **Edit**.
Create a New Page
To create a Wiki page you have several options.

Option 1: Main Toolbar
1. In the main toolbar, click +Add
2. Enter the Page Title and click OK. Text entered will determine the Page Name and the Page Title (heading 1).

Option 2: Using Brackets
• On any existing page, click Edit.
• Type [[Example Wiki Title]] where you would like the link to appear.
• Click Save, then Yes to create the new Wiki page.

Option 2: Existing Page
1. On any existing page, click Edit.
2. Click Int Link.
3. Click Add.
4. Enter the page title and click OK to create a new wiki page and link to it in the existing page.

Note: Page Name determines how the page is labeled in Search results. Both Page Name and page content factor in a search ranking.

**Edit a Wiki Page**

1. Open the page you want to edit.
2. Click Edit in the toolbar.
3. Enter the changes in the editing area on the left. Changes will show in real time as they will appear on the right.
4. Click Save or Save as Draft.

**Wiki Toolbar**

This toolbar appears across the top of the page when you create or edit a page.

- **Save**: Saves changes and closes the edit window.
- **Save as Draft**: Save a draft version of the page without altering the original. Wiki page edits are also automatically saved as drafts when Open Dental is force closed, such as during an update, as long as there are no code validation errors.
- **Cancel**: Close the window without saving changes.
- **Int Link**: Add a link to another wiki page.
- **Bookmark**: Add a bookmark to the top of a long wiki page to jump to a specified section of that page.
  - 1. Open the wiki page, click Edit.
  - 2. Scroll to the section you want to bookmark.
  - 3. Click Bookmark. Enter an ID and a Display Text. These do not have to match.
  - 4. Click OK.
  - 5. Cut the &lt;a href="#displaytext"&gt;&lt;/a&gt; code and paste it where you want the link to appear, typically at the top of the page.
  - 6. The &lt;div id="ID"&gt;&lt;/div&gt; code marks where the bookmark will jump to.
  - 7. Click Save.
- **File**: Add a link to a file on the network.
- **Folder**: Add a link to a folder on the network.
- **Ext Link**: Add a link to an external website (enter the full URL path: http://www.mysite.com).
- **Heading 1, 2, 3**: Format text as Page Title (h1), Subtitle (h2) or smaller category (h3). Properties of all &lt;h&gt; tags can be customized in the embedded stylesheet.
- **Table**: (See below)
- **Image**: It must exist in the A to Z folders. (See below).
- **Lock**: Lock wiki page so that edits can only be made by users with Wiki Admin permission.
- **Undo**: Undo the previous action. Only able to undo one action.
- **Italic**: Italicize specific words or multiple lines at once.
- **Color**: Make the selected text red. Change the color by replacing the color name in the Markup, for example: color:blue. Not usable on links.
- **Font**: Change the font of the selected text. The default font family is courier. To change, edit the font name in the Markup (e.g. font: courier.) Other examples: times, serif, arial, etc.
**Formatting & Keywords**

Keywords: Add keywords to a page using the following pattern: `[[keywords: office, tasks, workflow, employee, end of day, closing tasks]]` Keywords can be inserted anywhere in the wiki.

Bulleted Lists: Use asterisks * without a space after them. A line without an asterisk ends the list. Deeper levels are not yet supported.
- *first item in list
- *second item
- *last item

Numbered Lists: Use hashes # without a space after them. A line without a hash ends the list. Deeper levels are not yet supported.
- #first item in list
- #second item
- #last item

Special Characters: The following characters are not allowed: &lt; and &gt;. If you need to use them, prefix them with an ampersand &amp;: Example: &amp;&lt; or &amp;&gt;

Images: To place an image in the Wiki, save it in the A-Z Folders in the Wiki subfolder. If an image doesn't exist, the page cannot be saved.
1. To import a file to this list, click Import and select the file.
2. Double-click on the image name in the Wiki list.

**Tables**

Table markup cannot be edited directly in the page. Instead you must use the Table interface. Borders are always 1, cellspacing 0, cellpadding 0. Carriage returns are allowed inside cells. There is no control yet over shading or colors.

Click Table to insert a table at cursor. Add or delete columns and rows on the right side of the screen.
• **Man Edit:** Manually edit table Markup.
• **L:** Move cell focus to the left
• **R:** Move cell focus to the right
• **Headers:** Define the column headers. You can modify column header text and column size.
• **Up:** Move cell focus up one row.
• **Down:** Move cell focus down one row.

**Copy/Paste Cells:** To copy data from an external table to a wiki table, you must be running Google Chrome. If it is a complex table, you may need to copy/paste in pieces. First, copy the external table cells. Then click Table, make sure there are enough columns, then click Paste Cells.

To bold the text within a cell, edit the text outside of the Table window.

**Wiki List**
In the [Wiki](1484), click Lists.
Wiki Lists are a way to store non-clinical data in a convenient table format. For example they can be used to store contact information or network devices. Wiki lists are stored as tables in the database, so they are both searchable and reportable.
Example of a wiki list used for storing contact information.

User's must have the Wiki List Setup security permission to add or delete columns, or to delete rows.

**View or Add a List**

In the **Main Menu** (592), click Tools, Wiki. Then click Lists in the top toolbar.

Double click on a list to open, or click Add to create a new list.

When you first create a list, there will be a static column on the left named “tablename” Num. This is the primary key column and cannot be moved or renamed. It can only change in width; any changes to heading will be ignored. If additional columns are added, the items in the list will be sorted alphabetically by the second column contents.

**Add a Row / Enter Data**

1. Open the wiki list.
2. Under Rows click Add.
3. Click on a value to enter text, or select from a dropdown menu.
4. Click OK to save.

**Add a Column**

1. Open the wiki list.
2. Under Columns click Add.

A new column will appear on the right. The default name is Column1.
3. Click Edit to make changes to the column header, width, or pick list options.
   - Double click in a Column Name cell to rename.
   - Double click in a Width cell to change column size.
   - Click Add to add pick list options. To remove an option, highlight it then click Remove.
4. Click OK to save.

**Move or Remove Columns**
Move or remove columns from the main Edit Wiki List window.
1. Highlight a column, then click the L / R buttons to move it left (L) or right (R)
2. Highlight a column, then click Delete under Columns to delete it.

**Rename a List**
1. Open the wiki list.
2. Click Rename in the upper right.
3. Enter the name of the list and click OK. This name will be the identifiable name in the database, and will include no spaces or capital letters.
There are several ways to customize the wiki list search.

Enter the criteria in the Search field.
- If Highlight is selected, matching entries will highlight yellow and the list will automatically scroll to the first match.
- If Filter is selected, only the matching entries will display as unmatched entries are filtered out.

Click Adv. Search at the top to launch the Advanced Search window.

1. Select a column or columns to limit the search to only those columns.
2. Click OK. Search will change to Advanced Search in the Edit Wiki List window.
3. Click Clear to return to the normal search.

Generate a Query
Each wiki list represents a table in the database named using the follow format: wikilist_listname. You can generate a query from a wiki list using User Query(1382). Example: "SELECT * FROM wikilist_employeename"

Wiki Markup
Wiki(1484) pages are processed from wiki markup to html as they are displayed. The user edits the wiki markup and has no direct control over the actual html that results. Only the markup defined below is allowed. Any other html tags are not allowed, and the user will be forced to change them before the page can be saved. Most importantly, no attributes will be allowed other than those described. So no inline styles or any other typical html structures.

Links
Internal Links: [[Internal Link]] links to another page in the wiki. All characters are allowed in the title except \r, \n, |, and double quotes. After translation to html, it would look like this: &lt;a href="wiki:Internal Link"&gt;Internal
Link. If the internal link is to a wiki page that does not yet exist, then the html would look like this: 

```
<a href="/wiki:Internal Link">Internal Link</a>
```

, and the style sheet will likely cause this link to show with a dashed line under it as a visual cue. It's designed so that clicking on this link would cause a new wiki page to be created.

Bracket markup style is required. &lt;a&gt; tags are not allowed for internal links. To make internal links work in html, we intercept navigate events. If the user is trying to navigate to an internal page, we load that page into the browser control using C#.

**External Links:** External links must use ordinary &lt;a&gt; tags, like this: &lt;a href="http://www.somesite.com">somesite.com</a>.

**Files:** The following syntax is allowed for files.

```
[[file:C:\Storage\myfile.gif]]
[[file:\server\Storage\myfile.gif]]
```

After translation to html, they will look like this:

```
&lt;a href="wikifile:C:\Storage\myfile.gif">file:C:\Storage\myfile.gif&lt;/a&gt;

&lt;a href="wikifile:\server\Storage\myfile.gif">file:\server\Storage\myfile.gif&lt;/a&gt;
```

When the user clicks to navigate to one of these links, we intercept and pop up the file or the folder in a separate window.

**Folders:** The following syntax is allowed for folders.

```
[[folder:C:\Storage]]
[[folder:\server\Storage]]
```

After translation to html, they will look like this:

```
&lt;a href="folder:C:\Storage">C:\Storage&lt;/a&gt;

&lt;a href="folder:\server\Storage">\server\Storage&lt;/a&gt;
```

When the user clicks to navigate to one of these links, we intercept and pop up the file or the folder in a separate window.

**Text Formatting**

**Heading 1:** &lt;h1&gt;Heading for Top of Page is Big&lt;/h1&gt;

**Heading 2:** &lt;h2&gt;Headings for Sections are Smaller&lt;/h2&gt;

**Heading 3:** &lt;h3&gt;Headings for Subsections are Sometimes Needed&lt;/h3&gt;

Note: no other h tags are supported or allowed.

**Font:** &lt;b&gt;bold&lt;/b&gt; text and &lt;i&gt;italic&lt;/i&gt; text are supported.

**Text Color:** The syntax below is the only way to specify text color that is different than our master stylesheet.

```text
[[color:red|this text in red]] will be converted to &lt;span style="color:red">this text in red&lt;/span&gt;
[[color:FF0000|this text also in red]] will be converted to &lt;span style="color:FF0000">this text also in red&lt;/span&gt;
[[color:rgb(255,0,0)|more text in red]] will be converted to &lt;span style="color:rgb(255,0,0)">more text in red&lt;/span&gt;
```

**Bulleted Lists:** Use stars * without a space after them. Deeper levels are not supported yet. A line without a star ends the list.

**Numbered Lists:** Use hashes # without a space after them. Deeper levels are not supported yet. A line without a hash ends the list.
**Line Breaks**: &lt;p&gt; tags and &lt;br&gt; tags are not allowed in markup. During conversion to html, text that is not already surrounded by other tags gets surrounded by &lt;p&gt; tags. Each new line within a paragraph is then converted to another paragraph split with &lt;p&gt; tags. &lt;br&gt; tags are not used anywhere. The embedded styles leave zero margin at the tops and bottoms of paragraphs so that however many carriage returns the user types in is how many they will see in the final page.

**Spaces**: Spaces at the beginning of a line are converted to a series of &amp;nbsp; in html, which are hard spaces. Typing a tab on the keyboard while editing results in 5 spaces in wiki markup, which then get converted to 5 hard spaces in html.

**Special Characters**: The following characters are not allowed in markup other than as part of a valid tag: &lt; &gt; If you need to use them as not part of a tag, you must prefix them with &amp;, like this &amp;&lt; &amp;&gt; or &amp;&lt;.

**Images**

Images must first be placed in the A to Z(826) wiki folder. Then, they may be referred to in the markup like this: 
[[img:myimage.gif]].  
[[img:my image with spaces.gif]]

The image must exist, or the page edit cannot be saved. The Image markup is converted to html similar to the following:

```html
&lt;img src="file:///C:/OpenDentImages/wiki/myimage.gif"&gt;
```

Spaces at the beginning of a line are converted to aseries of  \( \) in html, which are hard spaces. Typing a tab on the keyboard while editing results in 5 spaces in wiki markup, which then get converted to 5 hard spaces in html.

**Special Characters**: The following characters are not allowed in markup other than as part of a valid tag: &lt; &gt; If you need to use them as not part of a tag, you must prefix them with &amp;, like this &amp;&lt; &amp;&gt; or &amp;&lt;.

**Images**

Images must first be placed in the A to Z(826) wiki folder. Then, they may be referred to in the markup like this: 
[[img:myimage.gif]].  
[[img:my image with spaces.gif]]

The image must exist, or the page edit cannot be saved. The Image markup is converted to html similar to the following:

```html
&lt;img src="file:///C:/OpenDentImages/wiki/myimage.gif"&gt;
```

Spaces at the beginning of a line are converted to aseries of  \( \) in html, which are hard spaces. Typing a tab on the keyboard while editing results in 5 spaces in wiki markup, which then get converted to 5 hard spaces in html.

**Images**

Images must first be placed in the A to Z(826) wiki folder. Then, they may be referred to in the markup like this: 
[[img:myimage.gif]].  
[[img:my image with spaces.gif]]

The image must exist, or the page edit cannot be saved. The Image markup is converted to html similar to the following:

```html
&lt;img src="file:///C:/OpenDentImages/wiki/myimage.gif"&gt;
```

**Tables**

Table markup cannot be edited directly in wiki page edit, but can be edited by clicking Man Edit in the Table interface. There is no control yet over shading or colors. Border are always 1, cellspacing 0, and cellpadding 2.

**Keywords**

A keywords tag, if desired, is usually placed at the top of the content, just under the main title.  
[[keywords: phrase1, phrase two, etc]]

During conversion to html, it will be changed to:

```html
&lt;span class="keywords"&gt;keywords: phrase1, phrase two, etc&lt;/span&gt;
```

The style for the keywords class can be set by the user in the master stylesheet. The search function will pick up on all words in the content, but it will give the highest priority to words found inside keywords tags.

**Technical Details**

The most recent version of each wiki page is stored in the database as text. Each revision is stored as an entire new entry. Images are stored in the A to Z folders in the wiki subfolder. Wiki pages are displayed in html in a browser control inside of Open Dental. But pages are not stored internally as html; they are only processed from wiki markup to html as they are displayed. The user edits the wiki markup and has no direct control over the actual html that results. The absence of a wysiwyg editor results in very consistent pages and fast editing. The instant preview lets users see changes as they work.

**Web Form Setup**

In the MainMenu(592), click Tools, Web Forms. Click Setup in the upper left corner.
Before a patient can access a Web Form, you must upload the Sheet(1123) to Open Dental’s web server, then construct the URL and provide it to the patient.

**Available Web Forms**
Lists all forms currently uploaded to the Open Dental web server. Click Add to upload a new web form. Click Update to update an existing web form. Click Delete to remove the selected web form from the server.

- **Add**: Click to upload a new web form.
Highlight a form, then click **OK** to upload it.

- **Note:** Every uploaded web form sheet must contain fields for LastName, FirstName, and Birthdate so that the completed, retrieved form can be matched to the correct patient. The Birthdate field should only be used once per sheet. If additional date fields are needed (e.g. insurance effective date), use the Misc input field instead. Forms can be uploaded or deleted from the server at any time without damaging patient records.
- Only sheets with a type of **patient form** or **medical history** are listed. Consent forms will also show if the option is checked on the Patient Forms window, but they are not allowed for use in webforms. Once you create custom patient forms or medical histories, only patient forms and medical histories list as options. If there are no custom patient forms or medical histories, the internal versions show.

- **Update:** If you edit a sheet after it has been uploaded as a web form to the server, it needs to also be updated on the Web Form server.
  - Option 1: Upload the form when updating the sheet. When you save changes to the sheet, you will be prompted to update the web form.
  - Option 2: Upload the web form again.
    1. Under Available Web Forms, highlight the web form.
    2. Click Update. If the server can identify the sheet the web form is linked to, the form will be immediately updated. If the server cannot identify the matching sheet, a list of sheet options will show. Select the sheet, then click OK to update.

- **Delete:** highlight an available web form and click to remove it from the server.

**Preferences**

These settings affect every web form uploaded to the web server. Click Save to save any changes to preferences.

- **Host Server Address:** The address where web forms are hosted. Do not edit this address.
- **Border Color:** The background color of the Web Form window. Click Change to select a different color.
- **Disable Web Form Signatures:** Select whether to allow signatures on web forms. Checked: Do not allow signatures on any web form. Unchecked: Allow signatures on all web forms.
Construct Web Form URL

Construct a URL: Build the URL patients will use to access the web form(s). Parameters in the URL also determine options available on the web form. Patients will use the web form URL to access the form via your website, email, etc.

- **Redirect URL**: Enter a URL to redirect the user to upon submission of the web form.
  1. Under Available Web Forms, highlight the web form(s).
  2. For Redirect, enter the full URL of the redirect (e.g. `http://www.yourwebsite.com/`). The URLs area will update to include the redirect code (`&ReturnURL=http://www.website.com`).

- **Next Forms**: Link multiple web forms together. Patients will see a list of all linked forms on the left side of their browser and can click on each one to move from form to form. The order of linked forms is always dictated by the order they are uploaded to the web server. All forms will still be submitted at once.
  1. Under Available Web Forms, highlight the first web form user will view.
  2. Click [...] next to Next Forms.
  3. Click the dropdown, then highlight the forms that will show 'next'. To select multiple forms, click and drag, or press Ctrl while clicking.
  4. Click OK. The URLs area will update to include code for the new 'linked' forms (`&NFID=12345`).

- **Clinic**: Associate the web form with a clinic. When a new patient fills out a form and no patient record exists yet, the clinic associated to the web form(s) will be assigned to the patient. This clinic will not override clinic selection on any existing patient records.
  1. Under Available Web Forms, highlight the web form(s).
  2. Click the Clinic dropdown to select the clinic, or click [...] to select from the Clinic List. The URLs area will update with the clinic code (`&CID=1`).

- **Inherit (Auto-Fill) Last Name, FirstName, and Birthdate from Previous Form**: On 'next forms', auto-fill the last name, first name, and birthdate from the previous form. To turn off this option for web forms in this URL, uncheck this box. `&AFNAB=N` will be added to the URL.

- **Disable Typed Signature**: Allow or block patient from typing a signature. By default, patients can type a signature in a web form signature box. To block typing of signatures for web forms in this URL, check this box. `&DTS=Y` will be added to the URL.

- **URLs**: As you build a URL, the box will update to include the URL code. To copy a URL, click Copy to Clipboard. To view the URL in a browser, click Navigate to URL.
Web Forms Retrieve
In the Main Menu(592), click Tools, Web Forms(1497).

When staff retrieves a Web Form, it is matched to a patient and viewable in the patient's Chart Module(298) and Patient Forms(1690). Up to 20 web forms can be retrieved at one time.

See our video on Mobile Web Forms: Web Forms Tutorial.

All web forms that have already been retrieved, for the date range, are listed.
- To change the date range, enter a new start and end date then click Refresh. Click Today to only view forms submitted today.
- If using clinics, you must be set to Headquarters in the Main Menu to retrieve web forms.
- To view forms submitted for a specific clinic, use the Clinic dropdown menu or click [...] to select multiple clinics. Use Headquarters to view forms not assigned to a clinic.
- To open a web form, double click it.
- To view all of the patient’s forms, right click on the row then click View this patient's forms.

Click Retrieve New Forms.
- Open Dental will attempt to automatically attach each retrieved web form to an existing patient.
- If an exact match is made, the form is automatically retrieved and viewable in Chart, Forms. See Web Form Logic below for details.

If a match is not made, you will be prompted to pick a patient.
- Matches: More than one patient with the same first name, last name, and birthdate was found for the web form. Double click the correct patient.
- Close Matches: No exact match was found for the web form. Choose a close match from the list, select an existing patient, or create a new patient.
The submitted last name, first name, and birthdate show at the top.
- Double click a match to attach the form to the patient.
- **Preview**: View the submitted form.
- **Select**: Select a patient that is not listed.
- **Discard All**: Deletes all unretrieved forms submitted with the exact same first, last, birthdate, and all included phone numbers. Use with caution to avoid losing real patient data. Intended to be used to clear out multiple test forms submitted under a test patient.
- **New**: Create a new patient record using the submitted information.

Note: When using Clinics, the patient's clinic will be set to the clinic associated to the web form.
- **Skip**: Do not retrieve web form at this time. Skipped forms will be available for download the next time web forms are retrieved.
- **Cancel**: Cancel retrieval of all web forms.

To import data from a patient form or medication history into the database, see [Import Patient Forms and Medical Histories](1692).

**Technical Details**
Open Dental uses the following logic to match retrieved web forms to patients.
- Initially Open Dental will attempt to match a patient based on last name, first name, birthdate.
- If only one exact match is found, the web form will be automatically retrieved.
- If there is more than one match, email address and phone number will also be considered. If at least one phone number or email address matches any phone number or email address on file, the web form will be retrieved. If neither phone nor email has a match, you will be prompted to pick a patient or skip retrieval.
- If there is no match at all, you will be prompted to pick a patient or skip retrieval.
Web forms that are successfully received are permanently deleted from the Open Dental web server. If a duplicate patient is created, see Merge Patients (1407).

To restore a web form that was deleted from a patient's chart, double click it. Click Restore at the bottom of the form.

**Web Forms: What Patient Sees**

In Web Form Setup (1497), click Navigate to URL(s).

There are slight differences between desktop and mobile views. The view is responsive and will automatically detect the user's device (desktop computer or mobile device) and adapt accordingly.

**Desktop View:**
- When multiple web forms are linked together ('next' forms), a link for each form shows on the left. Patient clicks a link to access each form. Unfilled forms are marked as **NEW**.
- When patient clicks Submit, **Required** fields are verified. If incomplete, the fields will turn red and patient will be asked to complete them. Forms with incomplete information are marked **REQ** on the left.

**Mobile View:**
- Three buttons show on the top of the device: Previous, Next, Submit. Submit is only enabled on the last form.
- **Required** fields are flagged in red and verified when patient clicks Next. Patient must complete all required fields to proceed to the next form.
Other details:

- The URL determines whether patient LastName, FirstName, and Birthdate is inherited on 'next' forms, whether there are 'next' forms, the clinic associated to the web form, whether a redirect occurs after submit, and whether typed signatures are allowed. See Web Form Setup(1497).
- Pale yellow areas indicate where the patient should enter information.
- Birthdate validation is based on Windows region settings (format, date format) for the office. To import patient birthdates successfully into Open Dental, make sure the region settings expected on the web form match the region settings on the workstation running Open Dental.
- If web form signatures is turned on (see Web Form Setup), patients can electronically sign web forms using a mouse or stylus, or they can opt to type their name. When the form is imported into the database by the office, a date stamp will appear in place of the signature. To erase a signature, click **Clear.** To type, check **Enable typed signature,** then enter the Full Name.
Font support is dependent on the browser used to view the form. If the browser doesn't support a font used in the form, a supported font will be substituted.

The form will be pure HTML with a little bit of JavaScript to validate certain fields.

Free-form drawing will not work.

Troubleshooting
Some of my customers are unable to view my web forms on mobile devices (e.g. cell phones) without scrolling to the right.
This occurs because the sheet the web form is based on has a fixed width (in pixels) that is too large for the screen size. Some workaround options include:

- Use a different device with a larger screen size, such as a personal computer or tablet. Most long forms, such as registration or medical history forms, are easier to fill in on personal computer due to the amount of information requested.
- Create a smaller custom sheet and use it as a web form option. This may include offering two links on your website: one for patients using a personal computer and another for patients using a mobile device with a smaller screen size.

In Mobile View, when a patient clicks (Add text) the screen darkens and patient is forced to scroll way down to find the text entry popup.
You have most likely embedded your web form in an iFrame. 2 options.

- Do not embed in an iFrame, just navigate the patient directly to the link provided by Open Dental.
- Call support so we can evaluate the height setup of your iFrame in your HTML source and help you format your iFrame in a way that alleviates this issue.

Would a patient (or parent/guardian) be able to digitally sign a web-based consent form?
The practice would do better to have the patient (or parent/guardian) complete the document online, then sign it in the office, rather than online.

Clinics
In the MainMenu, click Clinics.
The clinics feature is useful when you have multiple physical locations and offices want to use one database, yet keep information separated by clinic or location.

Use this menu to select the clinic. Only clinics the logged-on user has access to are listed as options. To set the default main menu clinic when logging on, see Miscellaneous Setup(921), Track Last Clinic by.

The clinic selection determines the following:
- The look of the Appointments Module(1).
- The default clinic when adding new patients. When Headquarters is selected, Unassigned is the default. If adding a patient to an existing family, the clinic of the family is the default.
- The clinic for new appointments.
- The lab case status indicated in the Appointments module. If Headquarters is the selected clinic, the status will reflect all lab cases attached to scheduled appointments in any operatory, including those with no clinic assigned.
- The employees that list in the time clock and the clinic associated with clock-in events.
- Which Alerts(1635) show.

Note: When there are more than 30 clinics, there is no option in the main menu to show hidden clinics.

Turn Clinics On or Off
In Show Features(806), check or uncheck the Clinics box. Click OK. Restart Open Dental.

Clinic Set Up
Enter information for each clinic in Clinic List(1223).

Assign a default clinic to each user and optionally restrict user access to clinics. See User Edit(1109), Assign Clinics.

Assign each patient a default clinic on the Edit Patient Information(62).

Review other clinic specific settings:
- Appointment Views(7)
- Clearinghouse Clinic Setup(647)
- Fee Override for Provider or Clinic(1206)
- XCharge Setup for Clinics(179) or PayConnect Setup for Clinics(172)
- Email Setup(747)
- Electronic Billing(514) (clinic overrides).
- Definitions: Clinic Specialties(862) (useful for Clone(145)).

Also see: Multiple Locations.

Logic
Clinic selection: Below are some helpful guidelines about the clinic options available for selection in various areas of Open Dental.
- Typically only clinics associated with the logged-on user are options (User Security Profiles, Assign Clinics).
- Unassigned means there is no clinic assigned to a patient, or, if used as a filter option (e.g. for reports) includes all patients who have not been assigned to a specific clinic.
- none means there is no clinic assigned (e.g. to payments, procedures, adjustments).
- All means all clinics the user has access to.
- Headquarters is the default interface option (accessible via the Main Menu, Clinics) for users with no default clinic. In
Schedule Setup and Time Card Manage, selecting Headquarters will filter the results to employees not assigned a clinic.

Operatories: If an operatory has a clinic set, all appointments scheduled in that operatory are automatically assigned that clinic. If an operatory has no clinic, the appointments will be assigned the patient's clinic. Operatories (628)

Claims: To ensure claims are always credited to the correct clinic, follow these guidelines.
- Make sure each procedure is assigned to the correct clinic when it is completed. To make it easier, assign clinics to specific operatories, and place appointments in those operatories so the correct clinic will be assigned by default.
- When the claim is created, it is automatically assigned a clinic based on the attached procedures, and this cannot be changed. If the wrong clinic gets attached to a claim, delete the claim, change all the procedures, then recreate the claim.
- Patient Payments: The default clinic for patient payments is determined by the setting in Account Module Preferences for Payments Use Patient Clinic. When checked, the clinic for patient payments will always default to the patient's clinic. When unchecked, the clinic will default to the clinic selected in the Main Menu.
- Claim Payments and Adjustments: Claim payments and adjustments default to the patient's clinic. If 'unassigned', the default will be 'none'.
- Time Clock: Each time clock event is associated to a clinic. When clocking in, the clinic selected in the Main Menu is assigned to the event. Subsequent clock out events use the same clinic.

Troubleshooting
- During HL7 import from eCW, clinics are not set for new patients.
- If Open Dental was used initially without the Clinic feature turned on, all patients that existed before turning on clinics will have no clinic (ClinicNum of 0). You will have to manually assign them. All new patients will use the defaults.
- If Open Dental was used initially without the Clinic feature turned on, any previously scheduled appointments will not update to include the clinic. You will need to manually add the clinic to each appointment or run the Update Provs on Future Appointments tool.

Find patients with no clinic: Run the Database Maintenance (1434) tool and check results for PatientsNoClinicSet. If patient's are found, then manually assign a default clinics. If needed, contact Open Dental Conversions for a service to associate clinics

Patient Dashboard
The patient dashboard is a customizable view of basic patient information that will display on the right-hand side of Open Dental.

In the MainMenu (592), click Tools, Patient Dashboards, then select your preferred dashboard from the available options.
Only dashboards marked as *Allowed* will list in the tools menu. To create and edit dashboards, see [Dashboard Setup](#) (1454).

If a database has more than 28 dashboards, a new window will open. Double-click a dashboard from the list to enable it.

See our [QuickTip: Patient Dashboard](#) video for a brief overview of setup and usage.

**Options**

To refresh a dashboard, refresh the module or right-click anywhere on the dashboard and select **Refresh**.
To close an open dashboard, right-click anywhere on the dashboard and select Close, or deselect the dashboard from the tools list.

**eServices Setup**

In the MainMenu(592), click eServices, and select an option to open the eServices Setup window.

![eServices Setup Window](image)

The active tab will depend on the option selected. Below is the Signup tab.

Sign up and setup for eServices is managed from the eServices Setup window.

- **Note:** The eService setup window will not be accessible until an eConnector has been installed.
- Changes made in the eService Setup window will be logged in the audit trail.

**Signup:** Sign up for eServices using the Signup Portal. eServices Signup(1510)

**eConnector Service:** Install and monitor the eConnector(1520). This service is used by all eServices hosted by Open Dental. You only need to install it once.

**Mobile Web:** Setup options for the Mobile Web. Mobile Web(1530)

**Patient Portal:** Setup options for the Patient Portal Feature (when hosted by Open Dental).

**Web Sched:** Setup options for Web Sched Recall(1600) and/or Web SchedNew Patient(1586).

**Texting Services:** View usage summaries for Integrated Texting. Integrated Texting(1610)

**Automated eReminders and eConfirmations:** Setup options for eReminders(1613) and/or eConfirmations(1620).

**Miscellaneous:** Set the run time of automated emails and text messages for Web Sched Recall reminders, eReminders, and eConfirmations. Unhide the Mobile Sync tab. eServices Misc(1634)

**Mobile Sync:** Access the old mobile sync preferences area. If this tab is not visible, see the Miscellaneous tab. Mobile Synch Feature
eServices Signup

In the **Main Menu** (592), click eServices, Signup.

The eServices Signup Portal lets you quickly sign up for eServices.

- **eServices Bundle**
- **eClipboard Feature**
  - **eClipboard Webinar**
- **eConfirmations**
- **Integrated Texting**
- **Mobile Web**
- **Patient Portal**
- **Web Forms**
- **Web Sched Recall**
- **Web Sched New Patient**
- **Web Sched ASAP**

The eConnector (1520) must already be installed and the logged-on user must have the *Security Admin* permission. If you have issues, please contact technical support.

The **Basic View** (1511) is active by default when there is only one location. The **Advanced View** (1515) is active by default when there are multiple locations/clinics.

Hover the mouse over a service to view service description and terms. Check the box next to each service to enable it. If you select the eServices Bundle, all boxes will check. The Total $ amounts will automatically update to reflect fees.
Integrated Texting access fee is included with eConfirmations. Per outgoing message fees still apply. Patient Portal and Web Forms are free for those on support. Thus, in the Signup Portal, these options are always checked.

For Integrated Texting:
1. Verify the country code. Per message fees vary by country.
2. Enter an SMS Warning Amount in U.S. dollars. This amount is per clinic and applies to every clinic. Once the amount is reached each month, you will be unable to manually send text messages until the amount is increased or a new billing cycle begins.

Example: If $20 is the amount and there are three clinics, each clinic has an amount of $20, but the total amount will equal $60.
   - Note: The SMS Warning Amount does not apply to or stop automated eReminders, eConfirmations, or Web Sched Recall text messages.
   - Phone numbers are automatically assigned in the Advanced View, Go to Basic View to choose from pool of phone numbers or use landline texting.

Click Save. New charges will be reflected within two billing cycles.

**Discontinue a Service**
To discontinue a service, uncheck its box in the Signup Portal and click Save. The checkbox status will change to pending stop (a square) indicating the eService will be stopped after the next bill date. Click the Info box in the upper right to see the Next Bill Date.

**Troubleshooting**
The Signup Portal window in Open Dental is blank with Internet Explorer 8 installed.
Update Internet Explorer or uninstall it. The Signup Portal is not compatible with IE 8. See [Computer Requirements](#).

**eServices Signup Basic**
In the **Main Menu** (592), click eServices, **Signup** (1510).
The Basic View is a simple view of eService sign up options. This view opens by default when there is only one location / clinic.

Clinic: If there are multiple clinics, a Clinic dropdown shows in the upper left. Select the clinic each clinic can sign up for different services.

Permission Level: The security permission level of the logged-on user. Users with the Security Admin permission can change eService settings. Users without this permission have read-only access.

Country Code: Used for Integrated Texting Feature only and determines texting phone number and per message fees. Select the country the practice is in. If you do not see your country, contact Open Dental support to see if the service is available.

SMS Warning Amount: Applies to Integrated Texting. Enter the amount (per clinic) to spend on outgoing text messages per month (in U.S. dollars, minimum $1.00). If you reach this amount, you will be unable to manually send text messages until the amount is increased or a new billing cycle begins.
This is a per-clinic limit that applies to every clinic. Example: If $20 is the monthly limit and there are three clinics, each clinic has a limit of $20, but the total amount will equal $60. This amount does not apply to or stop automated eReminders, eConfirmations, or Web Sched Recall messages.

**Mobile Settings**: Click to create login and registration details for use with the eClipboard mobile app.

- **User Name**: Create a username for use with the mobile app.
- **Password**: Create a password for use with the mobile app.
- **Re-Enter Password**: Confirm the password for use with the mobile app.
- **EmailAddress**: Register an email address for use in verifying identity and account recovery.
- **PhoneNumber (Optional)**: Register a phone number for use in verifying identity.

**eService, Price, Sign Up/Status**
- The Price column lists the per location monthly fee for the eService.
- Hover over a service to view information, eService terms, and in some cases the Hosted URL.

**eService Bundle**

<table>
<thead>
<tr>
<th>eService Bundle</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Our eServices Bundle package combines Integrated Texting, Mobile Web, eConfirmations, Web Sched Recall and Web Sched New Patient into one low discounted price per month per location.</strong></td>
</tr>
</tbody>
</table>

*Additional per message fees apply to texting*
• The Sign Up / Status column indicates whether the eService is currently active, pending stop, or inactive. Click in a box to change its status.
  o Checked: eService is currently active. Patient Portal and Web Forms are free for those on support thus they are always active.
  o Square: eService is pending stop, meaning it will stop on the Next Bill Date. When you disable an active service, the check mark changes to a square until the Next Bill Date passes.
  o Unchecked: The eService is not active.
Click the Info button in the upper right to view the Next Bill Date and an explanation of each status.

**Information**

<table>
<thead>
<tr>
<th>Active or Pending Stop eServices are available up to the Next Bill Date: 8/22/2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active - This eService is available for use.</td>
</tr>
<tr>
<td>Pending Stop - This eService can still be used up to the Next Bill Date.</td>
</tr>
<tr>
<td>Inactive - This eService is not available for use.</td>
</tr>
</tbody>
</table>

**Total:** As you select eServices, the total $ amount will update to reflect new charges. Click + to expand the total to list fees for each clinic:

**Save:** Apply eService changes. Charges will be reflected in your next statement.

**Integrated Texting Options**

There are two options available when signing up for integrated texting service:

**Auto Generate #:** Select this option to have a new number automatically assigned to your office for use with Integrated Texting.

Choose new #  $5
Use my Landline #  $20

**Integrated Texting**

Enter phone number

Offices in the USA and Canada have the additional option of requesting a local number. Click into the red outlined phone number field and the window below will appear:

**Choose Your Number**

Enter phone number

Enter your area code and click OK. This option is only available in the Basic View of the Signup Portal. Complete the signup process by making sure a monthly texting limit is entered above, and click the Save button at the bottom.
Use my Landline #: Select this option to sign up for the Integrated Texting service with your existing landline phone number. This is limited to Open Dental clients located in the USA and Canada.

Note: Customers using VOIP numbers may experience a delay in service and should work directly with Open Dental support. Please complete and return this Letter of Authorization to eServices@opendental.com.

The increased price for using a landline number for Integrated Texting or eConfirmations will display in green. The eService Bundle price remains the same.

When you click into the phone number field the following window will appear:

Enter your current landline phone number and click OK. Your number will be subject to an eligibility check and a verification process to ensure a number you do not own is not used in error.

- Note: Only US and Canadian numbers will work with this option. Mobile and some VOIP numbers are not supported.
- In rare cases, your telecomm provider may not support landline texting. Additionally, your telecomm provider may change suppliers at some time after you have signed up. This may result in your number no longer being available for this service, as not all suppliers support landline texting. In cases like these we can provide your practice with an alternate number utilizing a local area code.
- The only known VOIP number supplier (carrier) that does not support landline texting is Bandwidth. However, Bandwidth is a wholesaler. RingCentral, Google, Marchex and Skype are known to use Bandwidth.com phone numbers and known to switch your backend supplier without warning. Also see: Bandwidth

If you experience any errors while attempting to sign up please contact our Support Team to assist you.

For general usage information see: Integrated Texting(1610).

eServices Signup Advanced

In the eServices Signup Portal(1510), click the Advanced View tab.
This view opens by default when there are multiple locations/clinics.

**Country Code:** Used for Integrated Texting Feature only and determines texting phone number and per message fees. Select the country the practice is in. If you do not see your country, contact Open Dental support to see if the service is available.

**SMS Warning Amount:** Applies to Integrated Texting. Enter the amount (per clinic) to spend on outgoing text messages per month (in U.S. dollars, minimum $1.00). If you reach this amount, you will be unable to manually send text messages until the amount is increased or a new billing cycle begins.

This is a per-clinic limit that applies to every clinic. Example: If $20 is the monthly limit and there are three clinics, each clinic has a limit of $20, but the total amount will equal $60. This amount does not apply to or stop automated eReminders, eConfirmations, or Web Sched Recall messages.

**Permission Level:** The security permission level of the logged-on user. Users with the Security Admin permission have full permissions and can change eService settings. Users without this permission have read-only access.

**eServices:**
- If there are multiple clinics, there is a row for each location. Each clinic can sign up for different eServices.
- Under each eService column header is the monthly price, per location.
- Hover over an eService column header to view a description and service terms.

**eService Bundle**

<table>
<thead>
<tr>
<th>Clinic</th>
<th>eService Bundle</th>
<th>eConfirmations</th>
<th>Integrated Texting</th>
<th>Mobile Web</th>
<th>Patient Portal</th>
<th>Web Forms</th>
<th>Web Sched ASAP</th>
<th>Web Sched New Patient</th>
<th>Web Sched Recalls</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>North</td>
<td>$135/mo</td>
<td>$25/mo</td>
<td>$5/mo</td>
<td>$30/mo</td>
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<tr>
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</tr>
<tr>
<td>Totals</td>
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<td>$0/mo</td>
<td>$0/mo</td>
<td>$0/mo</td>
<td>$0/mo</td>
<td>$0/mo</td>
<td>$0/mo</td>
<td>$270/mo</td>
</tr>
</tbody>
</table>

*Additional per message fees apply to texting*
Each checkbox indicates whether the eService is currently active, pending stop, or inactive. Click in a box to change its status.

- **Checked**: eService is currently active. Patient Portal and Web Forms are free for those on support thus they are always active.
- **Square**: eService is pending stop, meaning it will stop on the Next Bill Date. When you disable an active service, the check mark changes to a square until the Next Bill Date passes.
- **Unchecked**: The eService is not active.

Click the Info button in the upper right to view the Next Bill Date and an explanation of each checkbox status.

**Active or Pending Stop eServices are available up to the Next Bill Date:** 8/22/2017

- **Active** - This eService is available for use.
- **Pending Stop** - This eService can still be used up to the Next Bill Date.
- **Inactive** - This eService is not available for use.

*eServices are available for use the instant you activate them. eServices will become inactive as of the Next Bill Date if flagged for Pending Stop.*

- **Totals**: As you select eServices, the total $ amounts will update to reflect new charges.

**Save**: Apply eService changes. Charges will be reflected in your next statement.

---

**Patient Portal Settings**

Users can customize the Patient Portal by selecting which features to utilize.

In eServices Signup (1510), click More Settings.
Overview of Setup Steps
1. Select portal features. See below.
2. Verify the patient portal URLs. See Patient Portal(1555).
5. Import code systems. See Patient Portal.

Portal Features
This process will determine which features are available to patients in the portal.

Select the features patients can see and use in the portal.
- **MakePayments**: Patients can make online payments using XCharge (OpenEdge)(173). For more setup information, see Online Payment Management(1563).
- **ModuleAccount**: Patients can view payments and statements.
- **ModuleWebMail**: Use Secure WebMail Feature to view, compose, and send secure messages between provider and patient.
- **ModuleCareSummary**: Patients can view, download, and transmit care summaries.
- **ModuleImages**: Patients can view and download PDFs or images stored in Images folders shared to the portal.
Click **Submit** to apply changes. It may take up to 15 minutes for changes to take effect.

**Import Coding Systems**
To allow patients to view care summaries in the portal, you must import standard code systems into Open Dental. We recommend importing all coding systems, but at a minimum import SNOMED CT Codes, CVX, and RxNorms. Also see Importing Code Systems(726).

1. In the main menu, click **Setup, Chart, EHR, then Code System Importer**.
2. Click **Check for Updates**.
3. Select the code systems, then click **Download Updates, Import**.

---

eServices Sign Up About
In the [Sign Up Portal](1510), the **About** tab displays read-only information based on your registration key.

```
About

**Program Version**
17.1.9.0

**Last eConnector Heartbeat**
Wed May 03 06:59:35 GMT-700 2017

**Legacy Type**
BillByRepeatCharge

**Listener Type**
ListenerServiceProxy

**Permission Level**
ReadOnly

**Is Reseller Customer?**
No

**On Support?**
Yes
```

This is used by Open Dental technical support for troubleshooting eServices issues.

**Program Version:** The version of Open Dental.

**Last eConnector Heartbeat:** The last time the eConnector heartbeat was detected.

**Legacy Type:** Historical billing information.

**Listener Type:** Indicates what the eConnector is doing.
**Permission Level:** The permission level of the logged on user. Those with Full Access (Security Admin permission) can change eServices. Those without have read-only access.

**Is Reseller Customer?** Indicates if there is a reseller registration key.

**On Support?** Indicates whether the location is currently on Open Dental support.

---

**eServices Signup Help**

The eServices Signup Portal lets you quickly sign up for and change eService preferences.

Note: To make changes in the Signup Portal, the logged on user must have Full Access permission level (Security Admin permission). Users without this permission have read-only access.

There are five clickable options:
- **Signup:** See [eServices Signup](1510).
  - Basic View (1511): The default view for single locations.
  - Advanced View (1515): The default view when there are multiple clinics.
- **More Settings:** Select Patient Portal features. See [Patient Portal](1555).
- **About (1519):** Basic information about Open Dental. Used by technical support for troubleshooting.
- **Contact Us:** Open the Contact page on www.opendental.com.
- **Help:** Open online help for the Signup portal.

---

**eServices Bundle**

**eConfirmations**

**Integrated Texting Feature**

**Mobile Web Feature**

**Patient Portal Feature**

**Web Forms Feature**

**Web Sched New Patient**

**Web Sched Recall**

**Web Sched ASAP**

Note: Fees always reflect charges for all enabled eServices, per clinic/location.

Patient Portal and Web Forms are free for those on support. Thus in the Signup Portal these options are always checked.

---

**eConnector**

The eConnector is used by all eServices to facilitate communication between Open Dental's secure servers and your office.

In the [Main Menu](592), click eServices, eConnector Service.
The eConnector only needs to be installed once. To check if the eConnector is already installed, go to eServices, eConnector Service.

- If the Current eConnector Service Status shows as *None*, the eConnector is not installed.
- If you are unable to connect, receive an error, or do not have the menu option, the eConnector is not installed.

**Current eConnector Service Status**: Displays the current status of the eConnector service.
- **Start**: If the status shows *Stopped*, click to attempt to start the service.
- **Install**: If not currently installed, click to attempt installation. See below for more details on this process.

**eConnector History**: Lists a status of eConnector events recording heartbeats, errors and other status changes.
- **Refresh**: Click to update the eConnector status history.
- **Ack**: Acknowledge an error showing in the service status.

**Send emails with a different process on the eConnector**: Check to use a separate process for email transmission. Intended for use of large offices experiencing email timeout errors.

**Stop Monitoring**: Click to terminate monitoring after eConnector has been uninstalled.

The following eServices utilize the eConnector service:
- Mobile Web
- Patient Portal
- Web Sched Recall
- Web Sched New Patient
- Web Sched ASAP
- eConfirmations
- eReminders
- Texting
- eRX (Dosespot)
For more technical guidance see the related links below.

- eConnector Firewall(1524)
- Update(1639)

**Install the eConnector on the Server**

Webinar: eConnector Installation

- Note: Only install the eConnector on one machine (typically the server).
- In Miscellaneous Setup, set the eConnector machine as the Update Server Name.
- The server should always be on and awake. If turned off, hibernating, or in sleep mode, eServices will not work until the computer wakes up.

1. Update to the most recent stable version.
2. Run Open Dental as an administrator.
3. In the Open Dental main menu, click eServices(1509), eConnector Service.
4. Click Install.
   - If you are prompted to allow the eConnector to begin listening for requests, click Yes.
   - If you are prompted to set your computer as the Update Server, click Yes.
5. When installation is complete, click OK.

If you receive an error indicating a need for manual installation, see Alternate / Manual Installation below.

**Install the eConnector on a Workstation**

Installing the eConnector on a workstation is only used when the server is not a viable option. First follow the same steps as installing on a server, then configure the eConnector service to run using administrator credentials. This requires technical knowledge and you may wish to contact your IT specialist.

1. Click Windows Start and open Services.
2. Right click eConnector, and open Properties.
3. Click Log On.
4. Select This Account.
5. Enter your administrator login credentials.
6. Click OK.

**Troubleshooting**

**Error when installing the eConnector**
Solution: Because the eConnector is a service, you may need to log in to Windows as a user with Administrative privileges and run Open Dental as an admin (right click, run as administrator).

**Error: Installer doesn't have access to the registry**
Solution: Login to Windows as a user with higher privileges (e.g. administrator) or manually install the eConnector (see below).

**Error: Failed upgrading to the eConnector service: Unable to install the service**
Solution: Run the setup.exe file on the host computer and try installing again.

**Antivirus software is restricting the eConnector**
Allow the eConnector through the Windows firewall.

**Error: An unexpected error has occurred: The program version linked to this EServiceAccount is invalid. Please start the EConnector and try again.**
Possible Solutions:
- Allow a firewall port for the OpenDentalEConnector.exe.
- Manually install the eConnector.
- If your network requires ports and IP addresses to be white listed, see Ports and IP Addresses for eServices(1527).
Alternate / Manual Installation

Sometimes the eConnector must be installed manually due to permission restrictions on the server or workstation.

1. Open the Service Manager. In the main menu, click Tools, Misc Tools, Service Manager (1412).
   Or, locate the Open Dental application folder. Depending on how Open Dental was installed, this may be C:\Program Files (x86)\Open Dental or C:\Open Dental. Double-click ServiceManager.exe to open.

Note: You do not need to uninstall the current Listener Service (OpenDentCustListener).

2. Click Add.

3. Enter or choose the Service Name. It must begin with OpenDent (e.g. OpenDentalEConnector).
4. Click Browse and select the OpenDentalEConnector.exe. Typically it is located in C:\Program Files (x86)\Open Dental\OpenDentalEConnector\OpenDentalEConnector.exe.
5. Click Install.
1. Enter your configuration settings. Set the Server to the name of your database host computer and verify the correct spelling of the database name.

2. Click OK to close the configuration settings window.
3. If this installation is successful, the status will change from *Not installed* to *Installed, Stopped*.
4. Click Start to start the eConnector service. The status will change to *Installed, Running*.

**eConnector Firewall**

These technical steps explain how to create an exception for the OpenDentalEConnector (*eConnector(1520)*) application to allow it through the Windows firewall.

1. Open the Control Panel and click Security.
2. Click Windows *Firewall*.
3. Click Advanced Settings, Inbound Rules.
5. Select Program, and click Next.
6. Select This program path, then Browse. The default location for the eConnector file is `C:\Program Files (x86)\Open Dental\OpenDentalEConnector\OpenDentalEConnector.exe`. 
7. Click Next, then click Allow the connection.
8. You may need to consult your IT department for profile selections.
9. Enter a Name and a Description (e.g. Open Dental eConnector).
10. Click Finish.

Ports and IP Addresses for eServices
The eConnector(1520), on some networks, requires ports and IP addresses to white listed.

Also see Firewall and Network and Computer Setup.

The following ports are needed to communicate with our servers:
- 49997 - This port is used by our Web Service internally for communication with eConnector.
- 49999 - This port is used by our Web Service internally for communication with eConnector.
- 50000 - This port is used for communication to the office database.
- 50002 - This port is used for communication via the TCP Socket, which facilitates communication back to our servers via the eConnector.
In some instances, IP addresses must be white listed as well. In these situations you will need to tie the port exceptions to the following IP addresses:

- 50.201.161.45:49997
- 50.201.161.45:49999
- 50.201.161.45:50000
- 50.201.161.45:50002
- 50.235.115.147:50000
- 50.235.115.147:50002
- 50.235.115.148:50000
- 50.235.115.148:50002

**eServices Troubleshooting**

Below is some general troubleshooting help if you experience issues with the eConnector or other eServices. For steps that relate to a specific eService, refer to the service’s troubleshooting page.

**Note:** Important: The server where the eConnector is installed needs to remain on at all times because the communication between our secure servers and your office relies on the Open Dental eConnector service. If the server is turned off, it disconnects our ability to communicate until it is turned back on.

- eServices that use a browser cannot be accessed on Windows phones.
- The eConnector is not compatible with Linux or Mac.

**Related Links**

- eReminder and eConfirmation Troubleshooting
- Integrated Texting Troubleshooting
- Mobile Web Troubleshooting
- Patient Portal Troubleshooting
- Web Sched Troubleshooting
- eServices Signup
- Ports and IP Addresses for eServices

**eConnector Down Alert (eServices not working)**

When eServices go down, you may notice the following:

- An eConnector Down alert (Main Menu, Alerts).
- eServices menu item is red (17.3 and earlier).
- Can’t load a page (e.g. Patient Portal, Mobile Web, Web Sched)
- Unable to send or receive text messages.
- eServices aren’t working and eConnector history is blank, even if the eConnector service appears to be started.
- On the eConnector window, the status of service is critical.
- In the Service Manager, the service has a status of installed, stopped.

To fix, follow these steps in this order. If one step doesn’t fix the issue, proceed to the next.

1. Check your internet connection and make sure the computer (and server if different) is always on.
2. Check that the service is running. In the Service Manager, check the service status. If it is not running, click Start.
3. If that doesn’t work, check these options:
   1. In the Service Manager, stop the eConnector service.
   2. In the Main Menu, click eServices, eConnector Service.
   3. Verify that Allow eConnector to communicate for eServices is checked and click Save.
   4. Wait a few seconds then restart the eConnector in Service Manager.
4. Reinstall Open Dental.
   1. In the Service Manager, stop the service.
2. On the computer that hosts the service, browse to server's A to Z Folder, right click on Setup.exe and run as administrator.
3. Restart the service.
4. In the Miscellaneous Setup set the Update Server Name to the name of the computer that hosts the service so all future updates occur from this computer.
5. In the Service Manager, uninstall the eConnector. Then reinstall it manually.
6. Check your firewall settings.
7. Check for errors in the eConnector log files (C:\Program Files (x86)\Open Dental\Open Dental EConnector\Logger).

Note: If eServices appear to be working on some workstations, but not others (e.g. alerts on some machines and not others), time differences between workstations and the eConnector host server can be the cause. Workstations that are not time synced to the eConnector server will show that eServices are down when they are not. To resolve this issue, change the time on the workstation to match the server.

**eConnector Error Alert**
Open Dental may generate an eConnector Error alert because of the following issues.
- Recent loss of internet service (e.g. if you turned off the computer hosting the service).
- You do not have a static IP address.
In version 17.3 and earlier, these issues caused the eServices menu item to turn yellow.

To remove the alert, mark it as read or delete it. Or acknowledge errors (in the main menu click eServices, eConnector).

**General Service Error Messages**
Could not reach HQ. Please make sure you have an internet connection and try again or call support. Unable to connect to the remote server.
See Ports and IP Addresses for eServices (1527).

**error code 200**
This can occur when trying to access a web page in the Patient Portal, Mobile Web or Web Sched, but the link has been edited in the browser. Retype the URL in the browser address bar using the exact URL provided for the eService in eServices Setup. If the issue persists, contact us.

**Failed to access registry**
This can occur during installation of eConnector. Log into Windows as a user with higher privileges (e.g. administrator) or manually install the eConnector.

**Failed upgrading to the eConnector service: Unable to install the service.**
Run the Open Dental setup file on the eConnector host computer and try the installation process again.

**Listener Version does not match Program Version**
The service was not stopped prior to updating Open Dental. In the Service Manager, stop the eConnector, then reinstall Open Dental.

**Message from: server - Unable to connect to any of the specified MySQL hosts**
Try to start the eConnector manually.

**Internet Explorer can't display this page**
Use a different browser.

**This is not an error...**
Ignore this error.

**Inner Thread Loop Failed**
Ignore this error.

**ValidatePatientPortal registraton failed**
This indicates that registration failed due to the previous error in the Event Viewer list. Check the previous error to troubleshoot.

**(in a logger folder) Object reference not set to an instance of an object**
Update to the latest stable version.
No immortal socket connection found for RegistrationKeyNum...
Open Dental headquarters cannot communicate with your eConnector. Follow the eServices are not working steps at the top of this page.

Error: MethodWebSchedRSs, unknown method: GetHeaderInfo.
Re-run setup file for current OpenDental version on server. There are likely missing .dll files for the eConnector that were missed on the initial update.

Access Issues
I recently changed my Listener Port or my IP address. Now I am unable to access eServices.
If you have bookmarked the long version of the URL used by the eService, it may be causing this issue. (e.g. for Patient Portal or Mobile Web), this may be causing the issue. This was a version related issue. We recommend updating to the latest stable version or bookmarking the short URL instead. Typically the short URL generated by Open Dental will look something like this:
https://www.patientviewer.com/?ID=abc123.

Firewall Troubleshooting
There are often issues communicating through firewalls when eServices are set up on a host computer. Below are some instructions for making an exception in the Windows firewall to allow communication. Make an exception in the Windows firewall for the eConnector application. See eConnector Firewall(1524).

Mobile Web
In the MainMenu(592), click eServices, Mobile Web.

To begin using Mobile Web, first Sign up(1510) for the service.

Set up Mobile Web Users
To access the Mobile Web, a user must meet security requirements. This means they must have:
• The Mobile Web security permission. See User Group(1115).
• Passwords must be strong must be enabled in Global Security Settings(1107).
• Users must have a strong password. See Change Password(598).

A entry is logged in the audit trail every time a user logs into the Mobile Web.

Get the Mobile Web URL
To access your Mobile Web, use the hosted URL that is linked to your unique Open Dental registration key. To find the URL:

- In the window above, right click on the Hosted URL, and copy it to the clipboard.
- In the Signup Portal, hover over Mobile Web. To copy the URL to the clipboard, click the button to the left of the field.

Mobile Web Home

In a supported internet browser, go to your Mobile Web URL.

For a demo, use the User Name: demo

User Name

Password

Remember User Name

Sign In

Enter your Open Dental user name and password, and press Sign In.

Hint: Check the Remember User Name checkbox to remember the user name the next time you log on.

After five failed logon attempts in a row, a user will temporarily be locked out of the account for five minutes or until a user with Security Admin privileges manually unlocks the account (See User Edit(1109)).

Note: To log on, a user have the Mobile Web security permission and a strong password.

Home Screen

The Home screen is the central location for accessing Mobile Web information.
Patient and appointment information is filtered by clinic. If the logged-on user has access to multiple clinics that use Mobile Web, the default clinic upon logon will be the clinic active the last time the user logged on or closed Open Dental. To change clinics, click the down arrow in the upper right, then Clinics.

Press an option to access.

- **Appointments**: View patient appointments and appointment details by date. [Mobile Web Appointments](1533)
- **Patients**: Search for a patient and view contact information. [Mobile Web Patients](1535)
- **Pharmacies**: View pharmacy contact information. [Mobile Web Pharmacies](1541)
- **Operatories**: View the appointment schedule by operatory. Add new appointments, or move, modify, delete existing appointments. [Mobile Web Operatories](1537)
- **eRx**: Prescribe medications through [DoseSpot](#), [Mobile Web eRx](1542).

In the upper right corner, press the down arrow to open an additional menu.

- **Home**: Return to the home screen.
- **Refresh**: Update content.
- **Clinic (Hill Valley)**: Change clinics. Only an option when the user has access to multiple Clinics that use the Mobile Web.
- **Logout**: Sign out of the mobile web.
On subsequent windows, press &lt; in the top left corner to go back one screen.

Mobile Web Appointments
In Mobile Web Home(1531), press Appointments.

The Appointments view will show scheduled appointments by day.

Appointment color is based on the treating provider, Appointment Types(619), or LateColor (Appointment View Edit(622)). The note that displays is from the Appointment Note. See Edit Appointment(20).

- Press an appointment to view more details.
- Press the arrows to the left/right of the date to move back (&lt;) or forward (&gt;) one day. Click the down arrow to select a date from a calendar or additionally filter by provider.

Appointment Details
- Press i to view Patient Details. Mobile Web Patients(1535)
- Press the Phone icon to call the patient.
- If complete information is not visible (...), press the information to view it in its entirety.
Calendar / Provider Options

- Press on a date to select. Press Today to select the current date.
- To filter by provider, press All Providers, then select the provider.
- Press OK to close the calendar and apply the filter criteria.

Knows a great deal of dental...
Mobile Web Patients

In the Mobile Web Home screen, press Patients.
From the Patients view you can search for a patient and view contact information, appointment history, allergies, and prescriptions.

Only active patients in the selected clinic are searchable. To list all patients, leave the Search field blank and press the magnifying glass. To search for a specific patient, enter first or last name, then press the magnifying glass to return matching results.

Select a patient to view more details.
Press a phone number to call it.
Press an email address to generate an email.
Press an appointment to view appointment details (see Mobile Web Appointments(1533)).

Mobile Web Operators
In the Mobile Web Home(1531) screen, press Operatories.
The Operators view displays appointments by operatory. You can also move, modify, delete, or create an appointment from here.

The current operatory showing is labeled at the top. To switch operators, press the down arrow and select a new one, or swipe left or right on the schedule.

- If using clinics, select the clinic first. All operators associated with that clinic will list.
- Press the arrows to the left/right of the date to move back (&lt;) or forward (&gt;) one day. Press the down arrow to select a date from a calendar.
- Each appointment displays the patient name, procedures, and Confirmation Status (17).
- Select an appointment to show Modify, Move, and Delete icons.
- Blockouts (10) will display but cannot be edited from Mobile Web. Changes must be made from the full program.
- Broken Appointments (55) will display with a big X:
Create a New Appointment
Press an available time slot in an operatory.

Note: If selecting a time slot that overlaps with a Do Not Schedule blockout a warning will appear.

Select the appointment start time.

Enter the appointment details.
- Press Select Patient to select from the list of active patients.
- Press the down arrows to select appointment status, confirmed status, provider, hygienist and appointment type.
- Enter the appointment duration.
  - Note: If an appointment type is selected, and the time duration entered matches the appointment type, the Appointment Time Pattern is retained.
  - If no appointment type is selected, or the time duration entered does not match the appointment type, the time pattern will add assistant time to meet the full time duration.
- Press Add Note to add an appointment note.

Press Save to create the appointment. It will immediately show in the new time slot.

Modify Appointment Information
Highlight the appointment.

Press the edit icon

to open appointment details.

Appointment status, confirmation status, provider, hygienist, duration, appointment type, and appointment note can be modified.
- Press a down arrow to select a new option.
- Type the duration in minutes.
- Press Add Note to add an appointment note.

Press Save.
Move an Appointment
Highlight the appointment.

Press the Move icon

Select a time slot to move this appointment
Smith, David
AccessTissGrExInSurg

Go to the new time slot in the correct operatory and press it.
Please select a start time for the appointment.

**Wednesday, June 21st**

<table>
<thead>
<tr>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>11:00 AM</td>
</tr>
<tr>
<td>11:10 AM</td>
</tr>
<tr>
<td>11:20 AM</td>
</tr>
<tr>
<td>11:30 AM</td>
</tr>
<tr>
<td>11:40 AM</td>
</tr>
<tr>
<td>11:50 AM</td>
</tr>
</tbody>
</table>

Select the Start Time.

The appointment will immediately show in the new time slot.
- Appointments will automatically apply Time Asked To Arrive.
- Provider/hygienist and appointment length will not change.
- Appointments moved to or from a prospective operatory (see [Operatories(628)]) will automatically update the patient status accordingly.
- The appointment's confirmation status is reset if moved to a different day.

**Delete an Appointment**
Highlight the appointment.
Press the delete icon

Press Yes to confirm or No to cancel.

**Mobile Web Pharmacies**
In the [Mobile Web Home](1531) screen, press Pharmacies.
The Pharmacies view is a list of all pharmacies and contact information as entered in the Pharmacies (1249).

If Clinics (1505) are enabled, pharmacies for the currently selected clinic will list. To view pharmacies from a different clinic press the dropdown arrow in the top right.

Select a pharmacy to view pharmacy address, phone, fax, and notes. Press a phone number to call it.

Mobile Web eRx
In Mobile Web Home(1531), press eRx.

- Note: Providers and proxy (non provider) clinicians can begin using DoseSpot to send ePrescriptions after DoseSpot Setup(343) is complete.
- When proxy (non-provider) users select the eRx button, they will need to select the provider they are creating the prescription for from the list. Providers who are scheduled for today will show. If the provider is not scheduled, they can use the "show all" box to see a full list of providers.
- Proxy users can only create pending prescriptions. A registered provider must complete the sending process.

For details on using DoseSpot on desktop, see DoseSpot eRx / Prescription(338).

Begin by searching for the patient. Press their name in the results list to open the DoseSpot Home Screen.
At any time press Walk Me Through for a guided tutorial of using DoseSpot.
Add Allergies

1. In the Patient Details dashboard, press **Add/Edit Drug Allergies**. Allergy information already entered for the selected patient shows here.
2. Check No Known Allergies if the patient has no allergies.
Add Drug Allergy

Current Drug Allergies

ALLERGY: Amoxicillin
STATUS: Active
REACTION TYPE: Allergy
REACTION:
ONSET:

Edit

No Known Allergies

Reset Fields

Name*

Status*

Reaction Type*

Reaction

Onset

MM/DD/YYYY

Save

Close

Walk Me Through
3. Fill in the information.
   o **Name**: Begin typing the drug name and a list will appear. Select the correct drug from the list.
   o **Status**: Select Active or Inactive. The default is Active.
   o **Reaction Type**: Select Allergy or Adverse Reaction.
   o **Reaction**: Enter the reaction the patient gets from the drug.
   o **Onset**: The date of the first occurrence of the allergy.
4. Press **Save**.

Prescribing a drug the patient is allergic to results in a warning in the Patient Details dashboard.

![Drug/Allergy Interactions](image)

**Add Existing Medications**

DoseSpot supports two-way medication syncing. Medications added to DoseSpot automatically list in Open Dental, and medications added in Open Dental automatically list in DoseSpot. Self-reported medications can be edited from both Open Dental and DoseSpot.

By default, all medications added in Open Dental import to DoseSpot as Patient Reported.

1. In the Patient Details dashboard, press **Add Patient Reported**.

![Add Patient Reported Medication](image)

2. In the Search field, begin typing the medication name and it will appear. Select the correct medication from the list. If the medication does not appear, manually enter it and press Add.
3. The medication will appear in Medications to Add.
4. Press **Save**.

Patient reported medications will appear in [Medications](#) in Open Dental and in the Patient's Active Medications area as a comment icon in DoseSpot.
**Add a Preferred Pharmacy**
You must add a pharmacy to the patient before medications can be sent electronically. Preferred pharmacies list under Add/Edit Pharmacies in the Patient Details dashboard.

```plaintext
<table>
<thead>
<tr>
<th>Medication</th>
<th>Dispense</th>
<th>Date</th>
<th>Dispensings</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acetaminophen</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
```

Showing 1 to 1 of 1 entries
Manage Patient's Pharmacies

Search By Patient

☐ EPCS

Reset Fields

Name:

Specialty:

Select A Specialty

Phone:

Fax:

Address:

City:

State:

State

Zip Code:

Search

Close

Walk Me Through
1. In Patient's Preferred Pharmacies, press **Add/Edit Pharmacies**.
2. Use Specialty dropdown to filter the pharmacy list, and enter the pharmacy info in the provided fields. Check the box for EPCS for EPCS pharmacies.
3. Press Search.
   Note: Try using fewer search criteria if you have trouble finding the correct pharmacy.
4. Press the preferred pharmacy from the results list to add it to the patient.
5. To remove a pharmacy, press Add/Edit Pharmacies and select the 'x' next to Pharmacy Name.

**Prescribe and Send New Medications**

Prescribing New Medications
1. In the Patient Details dashboard, Press **Add Prescription**.

2. In the Search field, begin typing the medication name and it will appear. Select the correct medication from the list.
3. Select the dosage amount listed under the medication.
4. Fill out the following fields:

Current medication: Norco (oral - tablet)

Schedule II

Click on the desired strength for this medication:

- 5 mg-325 mg
- 7.5 mg-325 mg
- 10 mg-325 mg
Effective Date: This is a required field for controlled substances, and must be within six months of the day the prescription is written.

Patient Directions

Dispense Amount

Number of Refills: Schedule II medications cannot have a refill. Enter zero (0) in that case. Schedule III, IV and V may have five (5) or fewer refills. Non controlled substances may have 99 or fewer refills.

Days Supply: Cannot exceed 365 days. Schedule II medications require this field and cannot exceed 90 days.

Check No substitutions if needed.

5. If your state requires it, add ICD/ADA code in the Pharmacy Notes. Click "+" above Show Pharmacy Notes to expand.
6. Click the star icon to save this medication to favorites.
7. Press **Save Prescription**.

**Sending New Medications**
1. On the Patient Dashboard, scroll down to Pending Medications.

![Pending Medications](image)

2. Check the box next to the medication to select it.
3. Enter the provider's PIN.
4. Press **Approve and Send**.

**Edit or Delete a Pending Medication:** Click the blue "+" button below the checkbox on a pending medication to access the Actions menu.
• **Edit**: Modify Pending prescription.
• **Delete**: Remove pending medication from the list.
• **Change Pharmacy**: Modify pharmacy for pending medication.
• **Start Prior Auth**: Begin a prior authorization for insurance.

**Non controlled substances**: Prescriptions are sent immediately and the status is indicated with a gray arrow in the Patient's Active Medications. After refreshing the page, the gray arrow will turn into a green check mark.

**Controlled substances**: The prescribing provider must Register for EPCS before sending. See [DoseSpot Setup](#)(343).
1. Confirm the pharmacy and prescription.
2. Click Ready to Sign.
3. Enter the provider's PIN. If needed, select the link to your state's PDMP website. You will need to provide your username and password.
4. Open the Duo Mobile app on the provider's mobile device and enter the two-factor authentication (TFA) code.
5. Click Approve & Send.

**Favorites**
Favorites are prescriptions that you have already set up and use commonly that can quickly be prescribed for a new patient. Favorites can be edited on an individual basis but will default to the information included when the prescription was favorited.

**Prescribing a Favorite**
1. In the Patient Details dashboard, click **Add Prescription**.
2. Select a drug and dosage amount from the favorites list, or begin typing a drug to narrow down the favorites list.
3. Verify the sig is correct and click **Save Prescription**.
4. Send prescription as normal.
Copying the Favorites List

The DoseSpot Favorite List is user specific. If you would like a list to be copied to another user, send an email to erx@opendental.com with the user's name and names of the users it should be copied to.

Mobile Web Troubleshooting

Below is some general guidance if you experience issues with the Mobile Web. Also see eServices Troubleshooting.

Issue: Planned and/or unscheduled appointments appear in the Appointment View after visiting a patient profile with planned/unscheduled appointments. The provider filter does not work as intended.
Solution: Press Menu, Refresh.

Customer not registered for MobileWeb Monthly Support
Solution: This can occur when a user clicks Get URL in eServices Setup, Mobile Web. Contact support to sign up for Mobile Web.

Strong passwords must be turned on. Go to Setup | Security to turn on strong passwords.
Solution: This can occur when logging into the Mobile Web. In Open Dental Security, check Passwords must be strong. Then have staff change their passwords to strong (at least 8 characters with at least one number and one uppercase letter).

Patient Portal

In the Main Menu, click eServices, Patient Portal.
The **Patient Portal Feature** is hosted by Open Dental and available to all customers on support. The **eConnector** is required for Patient Portal to work.

Customize which features are enabled in **Patient Portal Settings**.

**URLs**

URLs determine the web address patients will use to access the patient portal and/or make patient payments. Patients can go directly to the hosted URL (generated by Open Dental) or to the hosted payment URL.

In Open Dental's main menu, click eServices, Patient Portal.

**Patient Facing URL**: The web address given to patients to access the portal. It can be the hosted URL, or, you can use a page on your own website that redirects the patient to the hosted URL. This URL shows on the printout generated when granting access.


**Hosted URL**: The patient portal URL generated by Open Dental and linked to your registration key. Click Navigate to URL to open the URL in a browser. Click Copy to Clipboard to copy the URL to the clipboard.

**Destination**: Affects the Hosted URL.
- **Login Page**: The Hosted URL will take patients to the Patient Portal Sign in page.
- **Make Payment**: Adds &PAY=Y to the Hosted URL. The URL will then take patients directly to an area where they can make an online payment, without logging into the portal. Patients will still need to verify personal information and enter payment information. See **Online Payment**.

**Clinic**: Affects the clinic name listed in the header on the Hosted URL destination. Click the dropdown menu or [...] to select the clinic.

**Notification Email for Secure WebMail**
The notification email subject and message are used to create un-secure email notifications that alert a patient when a new Secure WebMail Feature is available in the patient portal.

- **Subject**: The subject of the email.
- **Body**: The email message itself. Make sure to include the tag [URL]; it will be replaced with a clickable link to the Patient Facing URL when the message is sent. This will allow patients to quickly access the patient portal login page to view the secure message.

Example: The email message in the screenshot above will look like this:

Please go to this link and login using your credentials.
https://www.opendental.com/login.html

- **Edit**: Click to edit HTML of email message. See HTML Email for details on use.
  Note: Edit Ram HTML option is not available for Patient Portal notification emails.

The email address set as WebMailNotify in Email Setup(747) will be used to send WebMail notifications.
1. In the main menu, click Setup, Manage, Email.
2. Highlight the email used to send WebMail notifications, then click WebMailNotify. An X will show in the Notify column.
3. Click OK to save.

To set up Invites, see Patient Portal Invites(1579).

**Patient Portal Host Diagram**

See Patient Portal(1555).
Host your own Patient Portal

The self-hosted web service validates that the customer is on active support at initialization (start up) and does not validate the registration key again until the web service is restarted. Hosting your own Patient Portal Feature is a highly technical process and does not require installation of the Listener Service. Open Dental does not provide support on this setup. We recommend you work with your IT professional.

Follow these steps to host your own Patient Portal.

1. Update to the most current stable version.
2. Purchase and install a certificate from any certificate authority for a few hundred dollars. You can reuse one if you already have it.
4. Change router settings and forward port 443 (https) to the computer where IIS is installed.
5. Allow all incoming traffic on port 443 through any applicable Firewalls.

6. Set up an IIS web service pointing to the Open Dental folder:
   1. Open the IIS Manager and right click on Default Web Site, then click Add Application.
   2. Set Alias to "OpenDental".
   3. Set Physical Path to the folder where Open Dental is installed (e.g. C:/Program Files/Open Dental).
   4. Click OK.

5. In the IIS Manager, expand Open Dental. Right click on the OpenDentalWebService folder and click Convert to Application. Click OK.
   
   Note: This folder will only be installed on the computer where the version update is performed. Our File Copier program will not copy the folder to other computers, so always perform updates on the server.

6. Set up the Patient Portal URL (see below). This process only needs to be performed once.
7. Patient Portal Access (1560). This process needs to be performed for each patient.
To have Open Dental host the Patient Portal, see Patient Portal(1555).

**Set up the Patient Portal URL**

1. Open the eServices Setup window, Patient Portal tab.
   - In the **Main Menu**(592), click eServices, Patient Portal.
   - On the **EHR Setup Window**(709), click Patient Portal.
   - From the Patient Portal window, click Setup.

2. In the Patient Facing URL box enter the URL patients will use to access the patient portal.

**If Using Secure Web Mail**

The notification settings create the insecure notification email that alerts a patient when a Secure WebMail Feature message from the provider is waiting in the patient portal.

- **Subject**: The subject of the notification.
- **Body**: The notification message. Include the [URL] tag; it will be replaced with a clickable Patient Facing URL when the message is sent. Thus, the email above will look like this: Please go to this link and login using your credentials. https://www.opendental.com/login.html
Patient Portal Access

Use the Patient Portal window to manually provide or remove access to the portal.

In the patient's Chart Module (298), Patient Information area, double-click the Patient Portal (1555) row.

Alternatively, in the EHR Dashboard (400), click Provide Online Access next to the ElectronicCopyAccess measure.

Note: To quickly open the Patient Portal access window, help staff quickly grant access to patients, and generate portal user names and passwords, add a Patient Portal row to the Patient Info area of the Chart Module.

In the main menu, click Setup menu, Display Fields (900), ChartPatientInformation, and move the Patient Portal field to the Fields Showing grid. The row will indicate whether patient has access or not. To provide online access, simply double click the row.

Patient Facing URL: The patient portal web address. Click Open to open the URL in your web browser.

Provide Online Access: Click to automatically generate a user name and password.
- Online Username: Defaults to the patient's first name plus a random number. It can be manually changed. The user name is not case sensitive.
- Online Password: A random 8-digit one-time use password. It can be manually changed but must have at least 8 characters, one uppercase letter, one lowercase letter, and one number. The password is case sensitive.

<table>
<thead>
<tr>
<th>Patient Info</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>38</td>
</tr>
<tr>
<td>Date First Visit</td>
<td>07/15/2016</td>
</tr>
<tr>
<td>Prov. (Pri. Sec)</td>
<td>Sparks, None</td>
</tr>
<tr>
<td>AskToArriveEarly</td>
<td></td>
</tr>
<tr>
<td>Pri Ins</td>
<td>Amicable Insurance</td>
</tr>
<tr>
<td>Sec Ins</td>
<td></td>
</tr>
<tr>
<td>Patient Portal</td>
<td>No access</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Online Username</th>
<th>Anderson12391</th>
</tr>
</thead>
<tbody>
<tr>
<td>Online Password</td>
<td>m3E6Wjc4</td>
</tr>
</tbody>
</table>
Print: Generate a printout of the user name, password, and the patient portal URL to give to the patient.

For information about what the patients sees when they log in to the portal see Patient Portal: What Patient Sees(1572) and Authorized Representatives(1579).

• Note: Before you can grant access to the Patient Portal, your hosting service must be setup. See Patient Portal(1555).
• One-time use passwords generated by Open Dental will be valid until the patient changes their password, or until a different password is generated in Open Dental (manually or via a sheet or invitation).

Change User Name or Password
User names and passwords can be manually changed by staff at any time.
1. Open the Patient Portal window. The current user name will show and the current password will show as asterisks.
2. To manually enter a new user name or password, type it in. To automatically generate a new password, click Generate New.
3. Click Print to print a copy of the user name, password, and the URL.

Patients can also change their own password and user name in the portal.

Alternative Methods to Grant Access
• Set up Patient Portal Invites(1579) that are automatically triggered by a scheduled or completed appointment.
  o Patient portal invitations can be automatically emailed to patients a specific number of days before or after an appointment. Invites are only sent to patients who have not accessed the portal yet and who have an entered name, address, and date of birth. The invitation will include a one-time use password and user name the patient can use to access the portal. This service is optional.
• Generate a sheet that has the patientPortalCredentials Sheet Static Text Field(1133) on it.
  o Patient Portal user names and passwords can also be generated by including the patientPortalCredentials Static Text Field on any Sheet(1123). The credentials will only display on the sheet if the patient does not have online access at the time the sheet was created. The patient must also have an entered name, address, date of birth, email address, and phone number in the Family Module.
  o Example of text that will replace the patientPortalCredentials static text field:

Patient Portal Login

UserName: Ann123
Password: xxxxxxx
Note: Make sure to adjust the width and height of the static text field so all credentials display on the form.

Remove Online Access
Once online access is provided, the Provide Online Access button changes to Remove Online Access. Click to remove the patient's ability to login to the portal.

Patient Portal Troubleshooting
Below is some general guidance if you experience issues with the Patient Portal(1555).

Internal server error. Please notify the dental office to call support or try again later.
Solution: This occurs when a patient logs in and the service has a problem connecting to your database.
1. Check that the server computer (or the system where the service was installed) is on and running. When the server is off, patients will receive this message since the eConnector is not running and there is no access to the database.
2. Open the Service Manager(1412) (see Step 2) and verify the eConnector service is running. If the service manager is stopped, try and restart it. If it fails to start, access the Event Viewer.
3. If the service is running and you still have this message, it is likely an issue with your firewall. See eServices Troubleshooting(1528), Firewalls.
**Error code 104**
Solution: This occurs when, upon installation of the service, the first heartbeat hasn't registered with Open Dental servers. To troubleshoot:
1. Verify that the service is running on the system where the service was installed. See **eConnector**(1520).
   - If it isn't, then select it and try to manually start the service. If it starts successfully, try the link again. If the error persists continue to step 2.
   - If you receive an error, then access the Event Viewer.
2. If the service is running, check the internet connectivity.
   - If the internet is working proceed to step 3.
   - If the internet isn't working, check all connections. If needed contact your IT professional or call your internet service provider.
3. If you have anti-virus software running, try momentarily disabling it and try the link again. If this solves the issue you will need to make an exception in your anti-virus software for the port the eConnector Service is using (typically 25255). If this doesn't fix the problem contact us for further troubleshooting.

**Error Code 103**
Solution: The practice is no longer on Open Dental support and thus the registration key is no longer active or valid. Contact us to sign back up for support.

**Error: Your provider has not set up this patient to view the Continuity of Care Documents. Please contact your provider.**
Solution: This occurs when the patient tries to access the Care Summary (CCD) in the portal. Generally this only happens when the guarantor is viewing a dependent's care summary. It means that information required for the care summary is missing from the patient's chart (birth date, phone number, and address). Check that the patient in the care summary has birth date, phone number, and address fields filled out (**Edit Patient Information**) (62)). Another possible cause is that required code systems aren't imported. See **Importing Code Systems** (726) to import all coding systems (EHR needs to be turned on to import).

**Login Failed**
Solution: Patient likely entered the wrong username or password. Verify the patient's username and reset the password if needed (see **Patient Portal Access** (1560)). The next time the patient logs in to the portal, they can change their password so it is unique and known only to them (see **Patient Portal: What Patient Sees** (1572), Change Password).

**CCD generation failed to load, please contact your provider.**
Solution: This happens when the patient tries to access the Care Summary but you have not imported code systems into your database using the Code System Importer. Import all code systems except CPT codes.

**File not found**
Solution: This can occur when patients attempt to access WebMail attachments or statements in the Patient Portal
- Make sure the eConnector is installed on the same computer as the OpenDentImages folder.
- If you have a single location: Check each office computer to see if any workstations can access the file locally. If one or more workstations can, but the server cannot, verify the path to the OpenDentImages folder that is being accessed. It should be the same folder for all workstations and the server. If different folders are used, images may be stored in different locations, thus requiring the different folders to be merged into one OpenDentImages folder.
- On the machine hosting the eConnector, go to the Services Console. Search for the OpenDentalConnector, right click and select properties. Select the Log On tab, then select This Account. Enter the username and password of the windows administrator. Restart the eConnector, then refresh the patient portal.
- If you have multiple locations: If using CEMT and/or connecting to separate locations via Middle Tier, it is possible the document was saved in a directory not accessible to your office (e.g. a directory at a different location). See **Middle Tier** for advice regarding the OpenDentImages folder and requirements for multiple location access.

**Error: CallMethod, unknown class: BlobFileSTs.DownloadDocument**
Solution: This occurs if updating Open Dental from a computer that does not have the eConnector installed. Run the setup file in the OpenDentImages folder. Make sure to disable the eConnector service on the workstation that performed the initial update if it was installed.

**Error: OTK Creation Failed. Authentication Error.**
Solution: This occurs when attempting to access Patient Portal online payments. Your XWeb credentials are incorrect. You may need to contact XCharge to verify your credentials. See XCharge Setup(178) or XCharge Setup for Clinics(179) for information on entering your XWeb credentials.

Error: OnlinePassword in 'where clause'.
Solution: The eConnector is on the wrong version. Run the setup file again on the eConnector host PC then try starting the eConnector.

Error: TypeError: Cannot read property [property][property name]'.
Solution: The eConnector may not have been updated during the last update. Rerun the setup file on the eConnector host PC and restart the eConnector.

Error: The parameter 'address' cannot be an empty string. Parameter name: address.
Solution: Set up a reply address. Click Setup, Manage, Email. Double click to edit an existing email address or add a new one. In Outgoing Email Settings, make sure there is an email address in the Email address of sender field.

Online Payment Management
Patients can make online payments using the Patient Portal Feature and XCharge (OpenEdge)(173). Payments can be made with or without logging into the portal.

How it works:
1. Enable online payments for the practice/clinic in Open Dental and provide patients a way to access the online payments interface (see below).
2. Patient makes payment (with or without logging in to the portal).
3. In Open Dental, staff is alerted that online patient payments are pending.
4. Staff processes patient payment in Open Dental.

Set up Online Patient Payments
1. Set up XCharge (OpenEdge)(173). On the XCharge Setup window, enable X-Web for patient portal payments and enter the X-Web account settings.
3. Provide patients with a URL to access the online patient payment interface. There are several options:
   o On your website, provide a link to the Hosted Payment URL or Hosted URL. These URLs are visible on the Patient Portal Setup window. The Hosted URL directs patients to the Patient Portal Signin window. The Hosted Payment URL directs patients to an online payment interface. They must verify their personal information, then can enter payment information. Patients do not need to log in to the patient portal.
   o On statements, add the [statementURL] or [statementShortURL] output text field. See Statement Layout(1186). These URLs launch the Patient Portal Sign in window where patients can log in to view an online version of the statement or make a payment.
   o When generating statements from the Billing List, also trigger text messages that include a clickable URL to the Patient Portal Sign in window. Include the [StatementURL] or [StatementShortURL] variable in the text message to insert the clickable link (Billing Defaults(510)). Only statements with modes that match selected Sent text messages to these modes (Billing(504)) will receive a text message, as long as the patient is eligible to receive text messages. Integrated Texting Feature must be enabled.
Process Online Patient Payments
Payments made via the portal must be processed in Open Dental. This allows you to make payment splits, attach procedures, and/or attach the payment to a payment plan.

When the logged-in user is subscribed to Online Payments Pending Alerts(1635), the Alerts menu item in the main menu will indicate when online patient payments are pending. The menu item will highlight yellow when the alert is new and unread.

- Note: A pending payment is a payment that has not been marked processed in Open Dental. The charge itself is immediately processed with the credit card provider when the patient makes the payment.
- To mark the alert as read, select Mark As Read. This will reset the Alert () count and turn off the yellow highlight.
- To open the Pending Online Payments window, click Open Pending Online Payments. This will also mark the alert as read, reset the Alert () count, and turn off the yellow highlight.
- Credit cards token information for online payments is safely saved on the Credit Card Manage(277) window.

To process payments:
1. In the Main Menu(592), click Alerts, Pending Online Payments, Open Pending Online Payments, or click Tools, Pending Online Payments.
To update the list of Payments Needing Processing, click Refresh. To open a patient's account, right click on a row, then click Go to Account.

2. If using Clinics, select the clinic. Only payments for the selected clinic will show. Users can only view payments for clinics they have access to.
3. Double-click a pending payment to open the Payment(153) window.
4. Review the payment information.
   - Create paysplits if desired.
   - Check the Mark as Processed box.
5. Click OK to process the payment.
6. When all pending payments are processed, click Close.

**Manage X-Web Transactions**
All transactions made using X-Web can be viewed in Open Dental. From here you can also process voids and returns.

In the main menu, click Tools, X-Web Transactions.
All transactions that match the entered From/To Date and selected clinic will list.

**From/To Dates:** Determines the date range of transactions. The default date range is today.

**Clinic:** If using Clinics, select the clinic. Only transactions for the selected clinic will show. Users can only view transactions for clinics they have access to.

Right click on a transaction to select other options:
- Go To Account: Open the patient's Account module.
- Open Payment: Open the Payment window for this transaction.
- Void Payment: Void the transaction.
- Process Return: Issue a refund.

**Void a Payment**
If a transaction is eligible for a void, the payment can be voided from the X-Web Transactions window or the Payment window.

1. From the X-Web Transactions window, right click on the transaction and select Void Payment. From the Payment window, click Void.
2. A confirmation message will open.
3. Click Yes to process the void. If unsuccessful, an error will show. The most common cause of a failure is because the transaction is not longer within the eligible time frame. In these cases, process a return instead.

**Process a Return**

To issue a refund to a patient, follow these steps:

1. From the XWeb Transactions window, right click on the transaction and select Process Return. From the Payment window, click Return.

   ![XWeb window](image)

   The card information will auto populate and cannot be changed.

   2. Enter the amount of the return and a payment note.
   3. Click OK.

**Troubleshooting**

**Problem: In the portal, patients do not see the Balance Est and Make Payment button.**

Solutions: First make sure a statement has been generated. If that is not the reason, check that online payments are setup correctly (Check X-Web settings and make sure payments are enabled).

**Problem: OTK Creation Failed: Authentication Error**

Solution: Check your X-Web credentials. See XCharge Setup(178).

**Problem: A void fails.**

Solution: The transaction may not be eligible for a void. Process a return instead.
Online Payment
See Online Payment Management(1563).

Once online patient payments have been set up, patients can make online payments with or without logging in to the Patient Portal. The specific steps for making a payment varies based on the method the patient uses to access the interface. The different scenarios are described below.

Note: Online payments are only available for offices using XCharge (OpenEdge)(173).

Logged in to the Patient Portal
When a patient is already logged in to the Patient Portal, they can make payments via the Account tab. Credit card information is automatically saved. Also see Patient Portal: What Patient Sees(1572)
1. In the Patient Portal, click Account, then Payments tab.
2. Click Make Payment.
3. Enter the amount of the payment.
4. Enter a note that will be viewable to office staff.
5. Select the card to charge the payment to. To select a card already on file, highlight it. The payment will process instantly with the credit card provider. Otherwise, click New Card, enter the credit card information, then click Submit to instantly process the payment with the credit card provider.

Link to the Hosted URL
When patients are provided a link to the Hosted URL, the link launches the Sign In window. From there, patients can make a payment with or without logging in to the Patient Portal.

To make a payment without logging in:
1. On the Sign in window, patient clicks Make Payment.
2. Patient verifies personal information (First Name, Last Name, Birthday), then clicks OK.
Open Dental will attempt to verify the information with an existing patient. If validation is successful, the Payment Options window will open.

3. Patient enters payment amount and any notes, then clicks Continue.
4. Patient enters credit card information, then clicks **Make Payment** to instantly process the payment with the credit card provider.

**Direct Link to the Hosted Payment URL**

When patients are provided a link to the Hosted Payment URL, they can make a payment without logging in to the Patient Portal. The link launches the Verify Personal Info window.

1. Patient verifies personal information (First Name, Last Name, Birthday), then clicks OK. Open Dental will attempt to verify the information with an existing patient. If validation is successful, the Payment Options window will open.
2. Patient enters payment amount and any notes, then clicks **Continue**.
3. Patient enters credit card information, then clicks **Submit** to instantly process the payment with the credit card provider.

**StatementURL**

When a patient is provided a StatementURL on their statement, or in a text or email message sent with their statement, the URL launches the Sign in window. From there, patients can log in to see an online version of the statement and make a payment, or they can make a payment without logging in.

To view an online version of the statement and make a payment:

1. Patient logs into the Patient Portal.
2. Once logged in, the patient’s statement balance will show with two options:

   - **Make Payment**: Click to make a payment. Patient enters payment amount and credit card information, then clicks **Submit** to instantly process the payment with the credit card provider.
To make a payment without logging into the portal:
1. On the Sign in window, patient clicks Make Payment.
2. Patient verifies personal information (First Name, Last Name, Birthday), then clicks OK. Open Dental will attempt to verify the information with an existing patient. If validation is successful, the Payment Options window will open.
3. Patient enters payment amount and any notes, then clicks Continue.
4. Patient enters credit card information, then clicks Submit to instantly process the payment with the credit card provider.

Troubleshooting
Problem: Patient doesn't see a Make Payment link on the Sign in window.
Solution: Online patient payments is not enabled correctly.

Note: When using clinics, the Make Payment link shows on the Login window when any clinic has online payments enabled. If the patient's default clinic doesn't have it enabled, clicking the link will open clinic contact information instead.

Patient Portal: What Patient Sees
In an internet browser, navigate to the Patient Portal Patient Facing URL (provided on the printout).

Patients can access the Patient Portal using most web browsers or mobile devices. Below is a summary of what the patient or Authorized Representatives may see when they go to the Patient Portal.

Sign in
Enter the user name and password.

To auto-enter this username the next time you sign in, check Remember User Name.

Note: The first time the patient logs in, they will be prompted to change their user name. This is only an option during the first login. To change it, enter the New User Name, then click Submit.

You may be prompted to verify your personal information as required by certain payment processors.
Enter your first and last name, and birthdate. Click Privacy Policy to view, if desired. Click OK to continue the sign in process.

**Reset a Forgotten Password:**
1. Click *forgot password*.
2. Enter the User Name and click Next. An email will be sent to the user's email address.
3. On the Forgot Password window, enter the reset code found in the email.
4. Enter and verify the new password.
5. Click Log In.

**Sign Out of the Portal:** In the upper right of the portal, click Sign Out.

**Navigating the Patient Portal**
The patient can easily navigate the portal. Six clickable icons indicate each feature the patient can access.

- **Appointments:** View the patient's scheduled and completed appointments and other action needed items, such as eConfirmations that need confirmed and Web Sched Recall notifications that are still unscheduled.
- **Account:** View payments and statements. Make online credit card payments.
- **Treatment Plan:** View the patient's saved Treatment Plans(283).
- **WebMail:** View and send private Secure WebMail Feature messages (between provider and patient).
- **Care Summary:** View, download, or transmit EHR Summaries of Care(445). (EHR)
- **Images:** View PDFs and image files stored in Images Module(480) folders shared to the Patient Portal.

**Other Options:**
- **Contact Us:** View contact information about the practice or clinic.
**Patient Name:** The name of the currently logged on patient. Click the dropdown to select from three options:
- Change Password: Change the logged-on user's password.
- Family Information: View a summary of each patient's information.
- Manage Credit Cards: Add or remove credit cards used in the portal.

**Refresh:** Refresh information in the portal.

**Appointments**
The Appointments area shows all of the patient's appointments and any outstanding action items, such as sent eConfirmations that have not yet been confirmed, or Web Sched Recall notifications for appointments not yet scheduled.

Click **Schedule Appointment** to schedule a Web Sched Recall appointment. Click **Confirm Appointment** to confirm a scheduled appointment.

**View and Make Payments**
In the Account area, Payment tab, view pending and processed statements (by pay split), as well as statement summaries. Patients can also make a payment from here.

An asterisk indicates a pending online payment that has been processed by the credit card provider but still need to be processed in Open Dental. See **Online Payment Management** (1563).

**Make a Payment in the Portal:** Patients can make an online payment if they have a statement and **Online Portal Payments** is enabled.
1. Click **Make Payment**.
2. Enter the amount of the payment.
3. Enter a note that will be viewable to office staff.
4. Select the card to charge the payment to:
   - To select a card already on file, highlight it. The payment will process instantly with the credit card provider.
   - Otherwise, click **New Card**, enter the credit card information, then click **Submit** to instantly process the payment with the credit card provider.

To make a payment without logging in, see [Online Payment](1569).

**Manage Credit Cards**: When a patient makes a payment when logged in to the portal, credit card information is automatically saved. In the upper right, click the patient name, then **Manage Credit Cards** to add or remove credit cards.

- Click **X** to delete an existing card.
- Click **New Card** to add a new card.

**Download Statements**
In the Account area, Statements tab, download PDF versions of statements. Click the down arrow next to a statement to download.
View Treatment Plans
The Treatment Plan area lists the patient's saved treatment plans.

![Treatment Plan](image1)

WebMail
WebMail messages are private messages between the patient (or their authorized representative) and a provider.

![WebMail](image2)

There are two folders:
- **Inbox**: Messages received from the provider.
- **Sent Items**: Messages sent by the patient.

Click on a message to preview it in the bottom of the screen.
- **Bold message indicate an unread message.**
- **If the message has an attachment (e.g. a clinical summary), a paperclip symbol shows to the left of the message. To open an attachment, click on the link. Patients can only view attachments; they cannot upload and send attachments.**
- **The status of the message is indicated under Sent At.**

![Letter and Paperclip](image3)

- 📩 = Unread
- 💌 = Sent
- 📝 = Read

Compose: Click to create a new message to send to your primary provider. Enter the subject and message then click Send.
**Reply:** Click to reply to a message. Enter the reply, then click Send.

Note: Authorized representative can send message on behalf of any family member. Click the Patient Name (next to Regarding Patient), then select the family member.

---

**RE: Your appointment has been changed**

<table>
<thead>
<tr>
<th>Send To</th>
<th>Doctor Smith</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regarding Patient</td>
<td>Andrews, Buster</td>
</tr>
<tr>
<td>Subject</td>
<td>RE: Your appointment has been changed</td>
</tr>
</tbody>
</table>

Thank you. I will be there.

-----Original Message-----
Regarding Patient: Andrews, Buster  
From: Doctor Smith  
Sent: 2017-11-02 09:48  
To: Buster Andrews  
Subject: Your appointment has been changed

We have rescheduled your appointment for Tuesday, April 7. Please let us know if that does not work.

---

**View, Download, Transmit Care Summary**

This feature is primarily for EHR. Highlight a patient name to view the associated care summary. Click a Table of Contents link to jump to specific information. See EHR Continuity of Care Document (CCD) (414).

The patient can perform the following actions for each care summary:

- **History:** View a detailed dated history of all actions, including any taken by an authorized representative on behalf of the patient (e.g. the guarantor).

  ![Downward Arrow]

- **Download:** Download the care summary as a zip file.

  ![Rightward Arrow]

- **Transmit:** Transmit the care summary to another provider the patient has been referred to. This icon is only visible if:
  - A referral has been entered in Open Dental.
  - Direct trust has been established with the referring provider (see Email Direct Encryption (1666)) and it has been denoted on the provider's Add Referral window (1268) (Email Trust for Direct is checked).
View, Download Images and PDFs

The Images area allows patients to view and download PDFs and image files. Only items stored in an Images folder that is designated as Show in Patient Portal are listed.

Images display chronologically by date, oldest to newest. Click \(\downarrow\) to download the file.

Change Password

Patients can change their own password while logged into the portal.

1. In the upper right corner of the portal, click the patient name, then Change Password.
2. Enter the current user name and password, then enter and confirm the new password.
3. Click OK to change.
Authorized Representatives

Authorized representatives can view another patient's health information in the Patient Portal and receive Web Sched Feature notifications on another patient's behalf. Several settings in Open Dental control who is authorized to see a patient's health information.

Patients: Can always view their own health information.

Guarantors: By default, guarantors have access to all family member information. This is determined by the Allow Guarantor access to family health information in the patient portal option in Family Module Preferences. If checked, guarantors can view information for all family members; if unchecked they can only view their own information. This is a global setting that affects all guarantors.

Guardians: Can view health information for any patient for which they are designated as Guardian (Edit Patient Information, Family Relationships, Guardian is checked).

Responsible Party: Can view health information for any patient for which they are a responsible party (Public Health enabled, Edit Patient Information window, Responsible Party).

Patient Portal Invites

Users must be on one of the following versions or newer prior to enabling Invites:

V17.4.94, V18.1.61, V18.2.42, V18.3.23.

Patient portal invitations can be automatically emailed to patients a specific number of days before or after an appointment.

In the Patient Portal tab, click Activate Invites.
Invites are only sent to patients who have not accessed the portal yet and have an entered name, address, and date of birth. The invitation will include a one-time use password and user name the patient can use to access the portal. This service is optional. Invitations are sent to eligible patients once an hour.

First, set up patient portal rules (see below). When rules are complete, click **Activate Invites** to activate the service and begin sending invitations.

For other methods of granting access to the portal, see [Patient Portal Access](1560)

**Set up Patient Portal Rules:** Rules determine when automated invitations are sent and the message.

Note: When there are multiple clinics, you can create default rules that are used by all or some clinics, or different rules for each clinic. Automation can also be turned on/off per clinic.
1. Select the clinic and any clinic-specific settings.
   o To create default rules, select **Defaults** as the clinic, then create the rules.
   o To apply default rules to a clinic, select the clinic, then check **Use Defaults**.
   o To create clinic-specific rules, select the clinic, uncheck **Use Defaults**, then create the rules.
   o To turn on/off automation by clinic, select the clinic, then check/uncheck **Enable Invites for Clinic**.

2. Click **Add Invite** or double click an existing rule to edit.

3. **Enabled**: By default this is checked, meaning the rule is turned on. Uncheck to disable the rule.

4. **Send Time**: Set time preferences for sending the invitation.
   o **Before appointment**: Send this invitation hours/days before a scheduled appointment.
   o **After appointment**: Send this invitation hours/days after an appointment is set complete.
   o **Days / Hours**: The amount of days/hours before or after an appointment the invite should be sent.
   o **Do not send within ____ of appointment**: Set a window of time, in relation to the appointment time, during which an invitation will not be sent. For example, do not send invitations within 3 hours of an appointment.
   Note: The automated eServices schedule also affects send time. See eServices Misc (1634). If an invitation is scheduled to be sent before the automated eServices start time, the Do not send value is ignored.

5. **Send Order**: Email is the only method of delivery available for patient portal invitations.

6. **Email Subject and Body**: Customize the email message. The first text box is for the subject line. The second text box is for the body text.

   To insert data from the database into the message text, use Template Replacement Tags.
   o [ApptDate]: The date of the appointment.
   o [ApptTime]: The start time of the appointment.
   o [ApptTimeAskedArrive]: The time the patient is asked to arrive.
   o [ClinicName]: The name of the clinic.
   o [ClinicPhone]: The phone number of the clinic.
   o [EmailDisclaimer]: This statement includes Practice (931) or Clinic (1223) address and instructions about how to unsubscribe from eService emails (see example below). The statement is only included in emails sent for Web Sched ASAP (1594), Web Sched Verify (1606), Web Sched Recall (1600), eConfirmations (1620), eReminders (1613), Patient Portal Invites, the Confirmation List (35), and the Recall List (27).

   Example:

   This email has been sent to you from:

   North Clinic

   123 Walrus Way

   Portland, OR 97338.

   How to unsubscribe:

   If you no longer want to receive any email messages from us, simply reply to this email with the word "unsubscribe" in the subject line.
   o [NameF]: Patient's first name.
   o [Password]: A Open Dental generated one-time password the patient can use to access the portal the first time.
   o [PatientPortalURL]: The web address the patient will use to access the portal.
   o [PracticeName]: The practice name.
   o [PracticePhone]: The practice phone number.
   o [ProvAbbr]: The abbreviation for the provider the appointment is scheduled with.
   o [ProvName]: The provider the appointment is scheduled with.
   o [UserName]: The username the patient can use to access the portal the first time.

   Note: Click **Edit** to open the HTML Email editor and further customize the invite email.

   Example

   [NameF],
In preparation for your upcoming dental appointment at [OfficeName], we invite you to log in to our Patient Portal. There you can view your scheduled appointments, view your treatment plan, send a message to your provider, and view your account balance.

Visit [PatientPortalURL] and use this temporary user name and password to log in:

User name: [UserName]
Password: [Password]

If you have any questions, please give us a call at [OfficePhone], and we would be happy to answer any of your questions.

7. Click **OK** to save the rule.

We recommend testing the rule and message prior to sending. Make sure you meet character limitations, that replacement tags work, and that the message appears as intended.

Aggregated Messages: When one or more appointments on the same day share a common patient email address, the associated patient portal invites will be grouped together into one email. To customize aggregated messages:

1. On the Edit Patient Portal Invite Rule window, click **Advanced**.
2. Change the email template as needed. See below for a description of each field.

3. Click OK to save and return to the Edit Patient Portal Rule window.

Note: Clicking Cancel to close the window will also close the Edit Patient Portal Rule window without saving any settings.

**Template Replacement Tags**: A list of valid template replacement tags that can be used to insert data from the database into the message.

**Email Subject**: The subject line. *Patient Portal Invitation*
Email Template: The text and template replacement tags in general message. The tag [Credentials] is required and will represent each patient's user name and password.

[NameF],

In preparation for your upcoming dental appointments at [OfficeName], we invite you to log in to our Patient Portal. There you can view your scheduled appointments, view your treatment plan, send a message to your provider, and view your account balance.

Visit [PatientPortalURL] and use these temporary user names and passwords to log in:

[Credentials]

If you have any questions, please give us a call at [OfficePhone], and we would be happy to answer any of your questions.

Note: Click Edit to open the HTML Email editor and further customize the invite email.

Email Template Per Appointment: The text and template replacement tags used in each [Credentials] tag.

[NameF]

User name: [UserName]
Password: [Password]

The email template above would result in the following message:

Ann,

In preparation for your upcoming dental appointments at North Clinic, we invite you to log in to our Patient Portal. There you can view your scheduled appointments, view your treatment plan, send a message to your provider, and view your account balance.

Visit http://www.patientportal.com and use these temporary user names and passwords to log in:

Ann
User name: ann
Password: 112lxxcl

If you have any questions, please give us a call at 503-555-5555 and we would be happy to answer any of your questions.

Web Sched

In the Main Menu, click eServices, Web Sched.
**Web Sched Recall**
Define available operatories, appointment types, and communication rules from [Web Sched Recall](1600).

**Web Sched Recall: What Patient Sees** (1604)

**Web Sched New Patient**
[Web Sched New Patient](1586) will guide you through enabling the feature and creating rules for new patient appointments scheduled online.

**Web Sched New Patient: What Patient Sees** (1590)

**Web Sched ASAP**
Unlike Web Sched for New Patients or Recall appointments Web Sched ASAP is not automated. [Web Sched ASAP](1594) is done from the [Appointments Module](1) by right clicking on an open time slot.

The [Web Sched ASAP History](1597) window is used to track messages sent and patient actions.

**Web Sched ASAP: What Patient Sees** (1599)

**Web Sched Notify**
[Web Sched Notify Setup](1606) governs optional confirmation messages sent for appointments created via each type of Web Sched.

**See Also**
[Web Sched Troubleshooting](1609)
Web Sched New Patient
In the Web Sched(1584), click New Patient Appts tab.

General Setup for Web Sched New Patients:
1. Sign up for Web Sched New Patient. See eServices Signup(1510).
2. Set up Appointment Types(619) for Web Sched New Patient appointments, then associate the appointment types to Web Sched New Patient Appointment type definitions (Definitions: Web Sched New Patient Appt Types(894)).
3. Set up operators that need to be considered for Web Sched New Patient appointments. Operators(628)
4. Verify options that affect appointments. See Appointment Options below.
5. Define the Hosted / Scheduling URL options for each location. See Hosted URL Options below.
7. Provide patients a way to access the Scheduling URL.
8. Turn on and customize Web Sched Notify Setup(1606) (optional).

Patient Requirements: In order to schedule a new patient appointment using Web Sched New Patient, patients must meet the following requirements:
- A patient record cannot already exist; patient must be new.
  Note: Patient’s match by first name, last name, and date of birth. If any of this information is typed incorrectly, a duplicate patient may accidentally be created.
- Patient must be 18 years of age or older, or a parent/legal guardian must confirm they are scheduling on a minor’s behalf.

Appointment Options
The settings below determine appointment openings in the Web Sched New Patient interface, as well as the default procedures and time patterns of scheduled appointments.

**Search for openings after [ ] days:** Enter the number of days in the future to search for the first available openings. Leave blank to include all available openings. For example, when 5 is entered, the first available opening offered to a new patient will be five days in the future. When left blank, an opening in the next 30 minutes could be offered.

**Confirm Status:** Select the [Confirmation Status](17) to apply to all appointments scheduled using Web Sched New Patient. The default is *Created from Web Sched*.

**Appointment Types:** These Web Sched New Patient Appointment Types determine the reasons patients can select for their appointment, as well as the appointment’s procedures, length, and time pattern. Double-click the grid to edit reasons and the appointment types associated with each.

**What is the reason for this appointment?**

<table>
<thead>
<tr>
<th>Select reason for appointment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Select reason for appointment</td>
</tr>
<tr>
<td>Check-up</td>
</tr>
<tr>
<td>Cleaning</td>
</tr>
<tr>
<td>Cosmetic</td>
</tr>
<tr>
<td>Tooth Pain</td>
</tr>
</tbody>
</table>

**Operatories Considered:** Lists the operatories considered for available time slots. Only operatories associated with *New Pat Appt Types* are operatories are considered. Double-click the grid to open Operator Setup.

**Blockout Types to Ignore:** By default, Web Sched New Patient does not consider *Blockouts* as available time. However, you can allow scheduling during specific blockout times by ignoring a blockout type. The box lists blockout times already ignored. To change settings:
1. Click Edit to open a list of all blockout types.
2. Highlight the blockout types to ignore (Web Sched New Patient appointments can be scheduled in the blockout).
3. Click OK to save.

**Available Times for Patients:** This area offers a preview of up to one month of open time slots for a location, based on the current settings.
1. **Date:** Enter the first date to preview or click Today to insert today's date.
2. **Clinic:** Select the location to preview.
3. **Reason:** Select the Reason / Appointment Type to preview.

When there are multiple operatories with openings at the same time, an appointment will be scheduled in the operatory on the farthest left of the schedule (order of 1).

**Hosted URL Options**

The Hosted URL is a unique web address issued to each location that signs up for the eService. You will need to provide a location’s Hosted URL to patients to allow them to schedule their new appointment online.

When a location has Web Sched New Patient enabled, enabled shows next to the location name in the Hosted URLs area.
For each URL, you can turn specific options on or off. Click + to expand a location's information; click - to collapse it.

**Options Grid:**

- **Allow Children:** Allow a parent or legal guardian to schedule on behalf of a minor patient (17 years of age or younger).
  
  When on, this preference will trigger an extra question (#3) if Pre-Screened Questions is also on:

  *Are you the parent or legal guardian of the minor patient?*
  
  - If Yes, proceed to scheduling calendar.
  - If No, patient cannot schedule online.

- **Show Pre-Screen Questions:** When on, this preference will prompt the patient to answer questions about their eligibility before accessing the scheduling calendar. This preference will trigger up to two questions

  - *Has this patient had an appointment with us before?*
    - If No, question 2 will be asked.
    - If Yes, patient cannot schedule online.
  - *Is the patient 18 years or older?*
    - If Yes, proceed to scheduling calendar.
    - If No, patient cannot schedule online unless Allow Children is also turned on (see below).

  If this preference is on, and Allow Children is checked and patient is a minor, patient will be instructed to submit guardian and minor information.

  If this preference is off, and Allow Children is checked and patient is a minor, patient will be instructed to submit minor information only.

- **Verify Email:** When on and a patient attempts to schedule a New Patient appointment, they will receive an email with a verification code. Code must be entered correctly on the Enter Verification Code window before they can proceed.

- **Verify Text:** When on and a patient attempts to schedule a New Patient appointment, they will receive a text message with a verification code. Code must be entered correctly on the Enter Verification Code window before they can proceed.

  Note: If guarantor is scheduling the appointment, the code will be sent to the guarantor’s email/wireless number as provided in the interface. If both Verify Email and Verify Text are both on, the same code is sent to both email and text.

- **Launch Web Form on Complete:** An X indicates selected Web Forms Feature will launch once a patient schedules their appointment. See Web Form to Launch after scheduling below.

  Note: If the preferences are off, no questions will be asked, but information entered on the scheduling window must still meet eligibility and age requirements before scheduling.

**Web Form to Launch after scheduling:** Click Edit to select one or more web forms to launch once a patient finishes scheduling their appointment online. The full URL of the web form(s) will display in the box. Right click to browse to the URL or copy it. Also see Web Form Setup (1497). Click red X button to clear field.

**Scheduling URL:** The full URL of the location’s Web Sched New Patient interface. Send patients here to schedule. Right click to browse to the URL or copy it.

There are two possible methods of providing access to the Hosted URL.

1. Add a link to the URL on your practice website. Then patients simply visit your website and click the link to schedule a new appointment.
2. Embed the URL in an iframe on your website. This will give the appearance of having Web Sched New Patient on your webpage instead of going to a different link. To see a demo: [http://patientviewer.com/demo/wsnp_embedded/](http://patientviewer.com/demo/wsnp_embedded/)
&ltd;iframe class="frame"
src="https://www.patientviewer.com/?RSID=34343338&amp;CID=30&amp;C=1251"&gt;&ltd;/iframe&gt;

**Other Interface Options**

These settings determine what patients see in the Web Sched New Patient interface, as well as the information they have to enter.

**Force US phone number format**: Determines the required phone number format. Check to force the U.S. format of 1-digits (XXX-XXX-XXXX). Uncheck to allow the patient to use any phone format.

**Allow patients to select provider**: When more than one provider has available openings, allow patients to select a provider. To add provider descriptions and photo that will be visible to the patient, see the Provider(1255), Web Sched tab.

**Prevent double booking**: Check to block double booking of appointments, even if Appointment Rules(617) would permit it.

**Appointment Message**: This message is intended to provide useful information to patients and will display when the appointment is being created. Click in the message to customize it. The default message is: Your first dental appointment with us will include a comprehensive exam, x-rays and a consultation with the dentist. The dentist will provide treatment options, recommend care and address any remaining questions.

**Other Options**

- **Change the interface color**
  By default, the Web Sched New Patient interface is blue. To change the color simply add this code to the end of the hosted URL: &amp;TCP=color. Replace color with the color name or hex value. If using a hex value, replace the hash (#) with a period (.)

  &lt;a href=
  "https://www.patientviewer.com/?RSID=34343338&amp;CID=30&amp;C=1251&amp;TCP=green"&gt;Schedule Appt&amp;lt;/a&gt;

  &lt;iframe class="frame"
  src="https://www.patientviewer.com/?RSID=34343338&amp;CID=30&amp;C=1251&amp;TCP=.507C77"&gt;&amp;lt;/iframe&amp;gt;

- **Redirect the patient to a specific URL after scheduling.**
  By default, a standard Appointment Booked message shows once an appointment is scheduled. To redirect the patient to a specific web page instead, simply add this code to the end of the hosted URL: ReturnURL=http://www.site.com. Replace www.site.com with the specific web page URL.

  &lt;a href="https://www.patientviewer.com/?RSID=34343338&amp;CID=30&amp;C=1251&amp;ReturnURL=http://www.opendental.com" &gt;Schedule Appt&amp;lt;/a&gt;

**Web Sched Notify Messages**

When a patient successfully books a Web Sched Recall, Web Sched New Patient or Web Sched ASAP appointment online, you can opt to send them an automated notifications via text, email, or both. To turn on and customize messages, see [Web Sched Notify Setup](1606).

**Web Sched New Patient Logic**

Below are additional details and information that affect Web Sched New Patient appointment openings, provider assignment, and appointment details.
New Patients: Before allowing a patient to schedule a new patient appointment, Web Sched verifies that a record for the patient doesn't already exist.
1. First it checks for a matching last name, first name, and birthdate. If no match, patient can schedule.
2. If a match exists, Web Sched compares the entered email address to the email address of all family members for whom a record exists. If no match, patient can schedule.
3. If a match exists, Web Sched compares the entered phone number to the phone number for all family members for whom a record exists. If no match, patient can schedule. If a match exists, patient cannot schedule.

Providers: Providers are assigned based on the operatory the appointment is scheduled in. It is important to assign a default provider to the operatory and/or assign the operatory to the provider's schedule time block. Providers cannot be marked as Not a Person in the Provider Edit window.

Available Appointments:
- Up to 3 months of available openings will be available for scheduling.
- The provider's Schedule Setup affects available openings. (Patients can't schedule appointments 2 months in the future if there is no schedule set 2 months out).
- The appointment schedule's time increment affects appointment start/end.

In Open Dental
- Scheduled appointments instantly show up in the Appointments Module.
- Alerts are created to notify staff a new patient appointment has been scheduled. See Alerts.
- Use the Web Sched Appointments Report to view and track appointments scheduled using Web Sched.

Troubleshooting
Web Sched Troubleshooting
eServices Troubleshooting
Web Sched New Patient: What Patient Sees

Web Sched New Patient: What Patient Sees
Below is a description of what a patient will see when all Web Sched New Patient interface options are enabled and they try to schedule their first appointment.

- Note: Some interface options are optional; see Web Sched New Patient to make changes.
- To see an example of Web Sched embedded in a website, see Sample Website.
  - This is only provided as an example of how the Patient Viewer can be embedded in a website to enhance its appearance. Open Dental is not able to embed or manage custom websites for your practice. Your IT and/or webmaster are your best resource if you wish to have Web Sched New Patient embedded in your site.

Eligibility Prompts
When prompts are enabled, the patient will first be asked a series of questions to determine their eligibility to schedule.
- A patient record cannot already exist; patient must be new.
- Patient must be 18 years of age or older, or a parent/legal guardian must confirm they are scheduling on a minor's behalf.

Question 1: Has this patient had an appointment with us before?
- Yes: Patient will be asked to call the clinic to schedule instead.
- No: Proceed to question 2.
Question 2: Is the patient 18 years or older?
- Yes: Proceed to scheduling.
- No: If the Allow Child prompt is enabled, proceed to question 3. If it is not enabled, patient will be asked to call the clinic to schedule.

Question 3: Are you the parent or legal guardian of the minor patient?
- Yes: Proceed to scheduling.
- No: Patient will be asked to call the clinic to schedule.

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North Clinic
123 Walrus Way
Portland, OR 97338
Phone: (503)111-1111

Are you the parent or legal guardian of the minor patient?
- Yes
- No

Is the patient 18 years or older?
- Yes
- No

Has this patient had an appointment with us before?
- Yes
- No

**Proceed to Scheduling**
Patient completes basic information and selects an available time slot.

**Reason for appointment:** Patient will select the reason for the appointment. The reason determines the appointment’s procedures, length, and time pattern.

**What is the reason for this appointment?**

- New Patient General
- New Patient General
- Emergency
- First Visit
- Other

**Select a Provider:** If you have opted to allow patients to select a provider, and more than one provider has available openings, patient can select a provider. To view a provider photo and description, click +. Click - to collapse provider information. +/- only shows when provider details have been added to the provider’s profile on the Provider(1255), Web Sched tab. There is no particular order of providers.
Select a provider

- Any
- Doctor Smith
- John Jones
- Harriet Hill

Dr. Harriet Hill graduated with honors from the Oregon Health & Sciences University in 1998. She is passionate about community service and regularly volunteers her time treating at-risk youth at the local Boys & Girls Club Dental Clinic. In her free time, she loves spending time with family and working in her garden.

Calendar: Patient selects a day and time, based on available time slots.

Guardian / Patient Info: Guardian or patient enters basic contact information.
Schedule Appointment: Patient clicks Schedule Appointment.

If Verify Email or Verify Text is turned on, patient will be prompted to verify their identity with a verification code.
Patient can select to receive the code via text, email, or both. Clicking Send will generate the code.

On the Enter Verification Code window, patient must enter the code correctly, then click Verify to proceed. Code is not case-sensitive and is only valid as long as the Enter Verification Code window is open.

If patient information meets requirements (new patient, 18 or over), a message will indicate scheduling success.

If you have set up web form to show after the appointment is scheduled, it will show instead.

If you have added a redirect URL to the code, the redirect URL will show instead.

**In Open Dental**

Scheduled appointments instantly show up in the [Appointments Module](#).

[Alerts](#) are created to notify staff a new patient appointment has been scheduled.

Use the [Web Sched Appointments Report](#) to view and track appointments scheduled using Web Sched.

**Web Sched ASAP**

Use [Web Sched ASAP](#) to quickly send email and/or text messages to patients on the [ASAP List](#) about last minute appointment openings. Messages include a clickable link patients can use to accept and reschedule their ASAP appointment. Patients also have the option to decline.
Related pages:
- Web Sched(1584)
- eServices Signup(1510)
- ASAP Message Setup(47) (email and/or text)
- Web Sched ASAP History(1597)
- Web Sched ASAP: What Patient Sees(1599)

Requirements:
- Patients must have an appointment or recall marked ASAP.
- To send text messages, Integrated Texting Feature must be turned on. Patients must also have a wireless number and allow text messages (Edit Patient Information(62)).
- To send email messages, patient must have an email address.

Note: Once a patient successfully books an online Web Sched ASAP appointment, you can optionally send them an automated notifications of appointment details. See Web Sched Notify Setup(1606).

In the Appointments Module(1), locate the available time slot you want to notify patient(s) about. Right-click on the available time slot start time, then select Text ASAP List. The ASAP List(43) will open:

**ASAP List**
All appointments whose length fits within the Start/End time will be selected by default. Information about the available time slot will show at the right in the Web Sched ASAP section.

- **Operatory**: Displays operatory of selected opening.
- **Start/End Time**: Click the down arrow to change.
- **Send**: Click to open Send Mode. Details below.
- **History**: Click to open Web Sched ASAP History.
- **Web Sched ASAP Messages**: View details about previously sent ASAP messages for all selected patients.

Highlighted patients will receive the Web Sched ASAP notification. Click **Send** to proceed to open Send Mode.

**Send Mode**

Select how to send the notification. Send Details will change based on your choice and additional details about send time will show in the upper right.

- **Text Message and Email**: Send both text and email messages.
- **Text Message**: Send text messages only.
- **Email**: Send email messages only.
- **Preferred contact method**: Send using the patient's preferred contact method (email or text message only).
Send Details will indicate what each patient will receive based on your selections and notes to explain the logic. Verify the message text and click Send to transmit messages.

**Web Sched ASAP Blockouts**
In the appointment schedule, a blockout will show on the available opening to indicate a Web Sched ASAP notification has been sent about the opening.

Web Sched blockouts can be deleted by right-clicking on them and selecting *Delete Web Schedule ASAP Blockout*.

**Send Details Logic**

**Text Messages:**
- Text messages are sent in staggered batches.
  - Texts will be sent for unscheduled appointments first, then scheduled appointments, then recalls.
  - Texts for appointments that are farthest in the future are sent first.
  - When the available time slot is less than 2 hours from the time the texts will send, texts are sent every minute.
  - When the available time slot is within 2 and 12 hours, the texts are sent every 2 minutes.
  - When the available time slot is within 12 and 48 hours, the texts are sent every 4 minutes.
  - When the available time slot is more than 48 hours in the future, texts are sent every 8 minutes.
  - Texts scheduled to be sent after the automated eServices End time are sent at the end time. Text messages are only sent during the automated eServices time window (*eServices Misc* (1634)), not necessarily when Send is clicked.
- The *Maximum number of texts to send to a patient in a day via Web Sched* affects how many Web Sched text messages can be sent to a patient per day. Defaults to 2. If a Web Sched ASAP notification is not sent because a patient has met their maximum number of texts for the day, the available opening will still be offered as a selection option in the Web Sched ASAP interface (e.g. if other notifications that include the URL have been sent).
- Once a patient opts out of future ASAP notifications for an appointment, they will no longer receive text or email Web Sched ASAP notifications for the appointment.

**Emails:** Emails are sent immediately when Send is clicked. They do not adhere to the automated eServices schedule.

**Text and Emails:** Notifications only are sent if the available opening is at least 30 minutes after the send time of the text and/or email.

**Web Sched ASAP History**
Use the Web Sched ASAP History window to track *Web Sched ASAP* (1594) messages that have been sent, as well as the action taken by patients.

On the *ASAP List* (43), click History.
From / To: Select the date range of messages to view, based on the Date Entry. Click the down arrow to select a date from a calendar; click the arrow again to close the calendar.

Clinic: Filter messages by clinic. Only visible when Clinics (1505) is turned on.

Web Sched ASAP Messages: A list of Web Sched ASAP messages that meet the filter criteria (date range, clinic). For each message, the following details show. Use the horizontal scroll bar to view details not initially visible.

- Patient.
- Status: The status of the Web Sched ASAP notification.
  - Appointment made: Patient accepted the appointment opening / rescheduled online.
  - Chose different time: Patient did not accept the opening offered in the message, but did accept a different opening and rescheduled online.
  - Unable to send: Message did not send.
- SMS Send Time: Date and time the text message sent.
- Email Send Time: Date and time the email message sent.
- Clinic.
- Original Appt Time.
- Slot Start: The start time of the available opening sent in the message.
- Slot Stop: The end time of the available opening sent in the message.
- Date Entry: The date and time a user clicked Send to send the Web Sched ASAP notification.
- SMS Message Text: The text message sent.
- Email Message Text: The email message sent.
- Note: Additional information about the message, such as why a message didn't send.

Appointment slots filled: The number of available time slots that were filled by patients rescheduling online via Web Sched ASAP.

Texts sent: The number of Web Sched ASAP text messages that were sent.

Close: Close the window.
Web Sched ASAP: What Patient Sees

Below is a description of what the patient will see when they receive a Web Sched ASAP notification.

1. Patient receives email or text messages about an available opening:

   Jimmy, an appointment opening has become available on 11/16/2017 at 2:40 PM at North Clinic. Visit [http://od.ag/a/f6r4dfi](http://od.ag/a/f6r4dfi) to reserve it.

2. Patient clicks link to open Web Sched ASAP.

If more than one Web Sched ASAP notification has been sent to the patient, there will be multiple appointment time options.

Patient has the option to accept or decline the appointment(s).

- Accept: Patient selects Date, appointment time, then clicks Accept. A message will indicate that the appointment has successfully moved.
- Decline: Patient clicks Decline. They can also opt out of future ASAP notifications for this appointment by checking Do not notify me about openings for this appointment.
In Open Dental

- The rescheduled appointment instantly shows in the appointment schedule and the appointment is no longer marked ASAP.
- Web Sched ASAP blockouts will remain on the schedule indefinitely.

Web Sched Verify Messages

To send automated notifications to the patient once they successfully book an appointment, see Web Sched Notify Setup (1606).

Web Sched Recall

In Web Sched (1584), click the Recalls tab.

General Steps to set up Web Sched Recall:

1. Sign up for Web Sched Recall (1510). To send text message reminders, also sign up for Integrated Texting.
2. Define options that affect available time slots (Operatories Considered, Recall Types, Blockouts and Provider Time).
4. Set Automation Options.
5. Turn on and customize Web Sched Notify Setup (1606) (optional).
6. Check patient information.
Search for openings after [ ] days: Enter the number of days in the future to search for the first available openings. Leave blank to include all available openings. For example, when 5 is entered, the first available opening offered to a new patient will be five days in the future. When left blank, an opening in the next 30 minutes could be offered.

Web Sched Recall Confirm Status: Select the confirmation status to apply to appointments scheduled using Web Sched Recall. To customize options, see Confirmation Status(17). Defaults to Created from Web Sched.

Operators Considered
Only operatories marked Is Web Sched are considered for available time slots for Web Sched Recall appointments. To change an operatory's setting:

1. Double-click a row to open Operators(628).
2. Double-click the operatory.
3. Check/uncheck the Is Web Sched box.
4. Save changes and close Operatory Setup.

Recall Types
Recall types (prophy, childprophy, and perio) determine due date intervals and time pattern/appointment length. To edit a recall type's settings:

1. Double-click a row in the Recall Types grid to open Recall Types(635) Setup.
2. Make changes as needed.
3. Close the Recall Types area. You may be prompted to synchronize recalls for all patients.

Blockouts and Provider Time
These settings affect available time slots for Web Sched Recall appointments.

Ignore Blockout Types: By default, Web Sched Recall does not consider Blockouts(10) as available time. However, you can allow scheduling during specific blockout times by ignoring a blockout type.

1. Click Edit to open a list of all blockout types.
2. Highlight any blockout types to ignore (Web Sched Recall appointments can be scheduled in the blockout).
3. Click OK.

Time Slots: Displays currently available time slots for the selected date and options to the right.

Provider Rule: Under the Available Time Slots area, select how provider selection affects available time slots.
- Use Defaults: Check to use Default Provider Rule defined under Default in the Clinic dropdown. Grays out below options for selected clinic.
- Clinic: Select Clinic from the dropdown list to choose clinic specific Provider Rule.
- First Available: Show available time slots for all providers.
- Primary Provider: Only show available time slots for the patient's primary provider.
- Secondary Provider: Only show available time slots for the patient's secondary provider.
- Last Seen Hygienist: Only show available time slots for the last hygienist seen by the patient.

Note: When there are openings in multiple operatories, appointments scheduled using First Available provider as the criteria will be scheduled in the operatory on the farthest left of the schedule (order of 1).

Prevent double booking: Check to block double booking of appointments, even if Appointment Rules(617) would allow it.

Allow patients to select provider: When more than one provider has available openings, allow patients to select a provider in the Web Sched Recall interface. To add provider descriptions and photo, see the Provider(1255), Web Sched tab.

The Available Time Slots area provides a preview of open time slots for up to a month, based on selected criteria:
- Date: The date of the first previewed opening (start date). Click Today to insert today's date.
- Recall Type: Filter open slots by recall type.
- **Provider**: Filter open slots by provider.
- **Clinic**: Filter open slots by clinic.

### Recall List Settings

Default settings for the Recall List affect when and to whom automated Web Sched Recall reminders are sent, as well as the message content. Click Recall Setup to review settings (see Setup Recall(632)).

Customize Messages: For both email and text, there are Web Sched messages for three reminders (first, second, third). Double-click on a reminder to make changes.

Below are examples of the default text for the first Web Sched reminders (1).

<table>
<thead>
<tr>
<th>Subject/Available variables</th>
<th>Dental Care Reminder for [NameFL]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Email body: Available variables: [NameFL], [DueDate], [ClinicName], [ClinicPhone], [PracticeName], [PracticePhone], [URL]</td>
<td>You or your family member is due for a regular dental check-up on [DueDate]. Please visit our online scheduler link below or call our office today at [OfficePhone] in order to schedule your appointment. Visit [URL] to schedule appointments or call [PracticePhone].</td>
</tr>
</tbody>
</table>

Variable options include:
- **NameFL**: Patient first and last name.
- **NameF**: Patient first name only.
- **FamilyList**: List first name and recall due date of all family members (if Group Families is selected).
- **DueDate**: Date the recall is due.
- **URL**: The unique link the patient will click to schedule their appointment. The generated link will be appointment and patient-specific and cannot be changed.
- **ClinicName**: Clinic name (patient's default clinic).
- **ClinicPhone**: Clinic phone number.
- **PracticeName**: Practice name.
- **PracticePhone**: Practice phone.
- **OfficePhone**: Uses clinic phone number if available, otherwise inserts practice phone.

Other Defaults: For automated reminders, patients are sent a Web Sched Recall reminder when they meet the default criteria for the Recall List (would show in the list today). We recommend reviewing the Recall List default settings.

A patient shows in the Recall List when:
- Their recall due date falls within the default date range and they have not yet received a recall reminder.
- They are due for a second or third reminder.

The date range is determined by these settings:

- **Days Past**: Determines the default Start Date.
- **Days Future**: Determines the default End Date.
Exclude: These options affect whether patients with scheduled appointments show in the list.
- Exclude from list if recall scheduled
- Exclude from list if any future appt

Reminders: Once the first Web Sched Recall reminder is sent, the reminder intervals affect when the second and third reminder are sent.
- Initial Reminder: The number of days after the first reminder to send the second reminder.
- Second (or more) Reminder: The number of days after the second reminder to send the third reminder.

### Automation Options
These settings determine automated preferences. Automation is optional. You can always manually send Web Sched Recall reminders from the Recall List (27).

**Send Email Messages Automatically To:** Select whether or not automated email Web Sched Recall reminders are sent, and if yes, to which patients.
- **Do not send:** Do not send automated email reminders to patients. This turns automated email reminders OFF.
- **Patients with email addresses:** Email automated recall reminders to any patient who has an email address.
- **Patients with email address and no other preferred recall method is selected:** Only email automated recall reminders to patients with an email address and no other Preferred Recall Method.
- **Patients with email addresses and email is selected as their Preferred Recall Method:** Only email automated recall reminders to patients with an email address who have also have email as their Preferred Recall Method.

**Send Text Messages Automatically To:** Select whether or not automated text Web Sched Recall reminders are sent, and if yes, to which patients.
- **Do not send:** Do not send automated text reminders to patients. This turns automated text reminders OFF.
- **Patients with wireless phone (unless Text OK = No):** Only send automated text reminders to patients who have a wireless phone number and are marked to accept text messages (Edit Patient Information (62), Text OK).

**Max number of texts sent every 10 minutes per clinic:** Determines how many messages are sent in a batch. Defaults to 2. Limiting the batch amount can be useful when there are many messages to be sent (hundreds) and you are worried about possible message failure. If blank, there is no limit.

Note: The automated eServices Schedule also affects when automated recall reminders are sent. See eServices Misc (1634).

### Web Sched Notify Messages
When a patient successfully books a Web Sched Recall, Web Sched New Patient or Web Sched ASAP appointment online, you can opt to send them an automated message via text, email, or both to notify them of appointment details. To turn on and customize messages, see Web Sched Notify Setup (1606).

### Patient Requirements
To receive a Web Sched Recall reminder, patients need to have basic information entered. We recommend checking the following for each patient on the Edit Patient Information window.
- Email address
- Wireless phone number
- Text OK status
- Preferred Recall Method
- If using clinics, make sure a default clinic is assigned.

### Technical Details
When using Web Sched Recall, make sure your general recall settings are correct. See Setup Recall (632).

Provider Assignment Logic:
- Providers are assigned based on the operatory the appointment is scheduled in (the provider of the operatory for the
time block). It is therefore important to assign a default provider to the operatory and/or assign the operatory to the
provider's schedule time block.

• The provider's Schedule Setup should extend as far into the future as you want to schedule appointments. You
can't schedule recall appointments 3 months in the future if there is no schedule set 3 months out.

Appointment Detail Logic

• The appointment schedule's time increment affects appointment start/end. See Time Increments on Appointment View
  Setup.

• Recall type time pattern determines appointment length.
• Recall type procedures determine the procedures on the appointment.

Clinic Logic: Web Sched will first check for available openings in operatories of the patient's clinic. If the patient has no
clinic, it will look at operatories for the clinic of the last scheduled or completed appointment. If no clinic can be
determined, only time slots in operatories assigned to no clinic are considered (operatories flagged Is Web Sched with
None as the clinic).

Aggregated Messages: When multiple family members are sent a Web Sched Recall reminder, the message will be
aggregated into one and a commlog will be generated for each patient. The aggregated message format cannot be
changed.

Aggregated text message recall reminder:
"Dental checkups due: [FamilyListURLs]. Visit links to schedule appointments or call [OfficePhone]."

Aggregated email message recall reminder:
"These family members are due for a dental checkup:"
"[FamilyListURLs]"
"Please visit the links above or call our office today at [OfficePhone] to schedule your appointment."

The "[FamilyListURLs]" tag will be replaced lines that look like this: "Harry - Schedule appointment at
http://od.ag/w/LWWhHh".

Troubleshooting

Web Sched Troubleshooting

eServices Troubleshooting

Web Sched Recall: What Patient Sees

In Open Dental

Scheduled appointments instantly show up in the Appointments Module.

Use the Web Sched Appointments Report to view and track appointments scheduled using Web Sched.

Web Sched Recall: What Patient Sees

Below is a description of what happens when a practice sends Web Sched Recall reminders to patients (automated or
manual) and the patients goes online to schedule. See Web Sched Feature for a description of the Web Sched Recall service.

One reminder for each recall appointment is sent to the patient's Authorized Representatives. Each reminder
contains a clickable link that is patient-specific based on patient number.

To schedule an appointment, the patient will follow these steps:

1. Open the reminder and click on the link in the message text to open Web Sched Recall in a browser.
Practice or clinic name, address, and phone number: Based on the information entered in Practice Setup (931) or Clinic List (1223) (patient's default clinic).

Patient info: Only the patient's first name and age shows. If the patient is over 89, 89+ shows. No PHI is displayed.

2. Select a Provider: If you have opted to allow patients to select a provider, and more than one provider has available openings, patient can select a provider. To view a provider photo and description, click +. Click - to collapse provider information. +/- only shows when provider details have been added to the provider's profile on the Provider (1255), Web Sched tab. There is no particular order of providers.

3. Calendar: By default, the first dates with available time slots show, based on criteria selected in Web Sched Recall (1600). Select a date and available appointment times will show. Then select the desired appointment time.
4. (optional) Check **Notify me if an earlier appointment time becomes available** to have the office notify patient about earlier appointments. This marks the appointment as ASAP and it will show on the ASAP List.
5. Click **Finalize Appt**.
6. A confirmation message will show. To confirm, click **Yes**. To return to the list of available dates, click **No**.

7. If Yes, a confirmation of the now scheduled appointment will show.

![Appointment Booked!](image)

**You may now close this browser session.**

8. Close the browser to end the session.

**In Open Dental**
- Scheduled appointments instantly show up in the **Appointments Module**.
- **Alerts** are created to notify staff a Web Sched Recall appointment has been scheduled.
- Use the **Web Sched Appointments Report** to view and track appointments scheduled using Web Sched.

**Note:** Once an appointment is scheduled it cannot be changed in Web Sched Recall. If a patient reopens the email link, they will be notified an appointment has already been booked.

**Web Sched Notify Setup**

In **Web Sched**, click the **Notify** tab.
When a patient successfully books a Web Sched Recall, Web Sched New Patient, or Web Sched ASAP appointment online, you can opt to send them an automated message via text, email, or both to notify them about the appointment details. Notify messages can be turned on by clinic and by service.

Note: For more information about each service, see Web Sched Feature.

Each service has its own section: Recall, New Patient, ASAP. In addition, when you have multiple clinics, you can create default messages for all or some clinics, or customize messages per clinic.

Note: To undo all changes made since the window was last opened, click Undo All.

### Customize Messages (no clinics)

1. **Communication Method:** For each service, select the method of sending the notify messages.
   - None: Do not send notify messages for the service.
   - Text: Only send notify messages via text.
   - Email: Only send notify messages via email.
   - Text and Email: Send both email and text notify messages.
2. **Text Message:** Customize the message sent via text. Right click in the text box to insert a Message Replacement Fields that dynamically inserts patient data into the message text.
3. **Email Subject and Body:** Customize the email subject line and body text.
4. Click OK to save.

### Customize Messages (clinics)

When there are multiple clinics, you can customize settings by clinic.

1. **Clinic:** Select the clinic to apply the settings to.
   - To set defaults for multiple clinics, select Defaults, then change the settings.
   - To customize the settings for a specific clinic, select the clinic, uncheck Use Defaults, then change the settings.
   - To apply default settings to a clinic, select the clinic, then check Use Defaults.
2. **Communication Method**: For each service, select the method of sending the verify messages.
   - None: Do not send verify messages for the service.
   - Text: Only send verify messages via text.
   - Email: Only send verify messages via email.
   - Text and Email: Send both email and text verify messages.

3. **Text Message**: Customize the message sent via text. Right click in the text box to insert Message Replacement Fields that dynamically insert patient data into the message text.

4. **Email Subject and Body**: Customize the email subject line and body text.

5. **Edit**: Click to edit Email message HTML. See [HTML Email](#) for details on editing HTML elements.

Note: **Use Raw HTML** option does not work for WebSched messages.

6. Click OK to save.

**Message Replacement Fields**

Both email and text messages can include Message Replacement Fields that dynamically insert patient data from the database. The fields available for each service vary.

1. Right click in the Text Message, Subject, or Body text box, then click Insert Fields to view available Message Replacement Fields.
Fields in black text are available for the service. Fields in red text or not. Greyed out fields are considered protected health information (PHI) and cannot be inserted into text messages because texting is not a secure method of sending PHI.

2. Double-click a field to insert it in the current cursor location.

### Web Sched Troubleshooting
Below are some troubleshooting steps if you experience issues with Web Sched Recall, Web Sched New Patient, or Web Sched ASAP.

See [Web Sched](1584)
Problem: There are no available time slots for patients to choose from. Solution: Check all setup options to make sure information is complete and accurate.

- Does the provider's schedule extend far enough into the future? Schedule Setup (1099)
- Are operatories correctly marked for Web Sched? Operatories (628)
- In the Provider Setup, for each provider make sure Not a Person is unchecked. Provider (1255)

Web Sched New Patient Q: Why do I see 'Error Retrieving URLs’ in the Hosted URL title bar?
A: This message shows when you haven't yet enabled Web Sched New Patient, or when there are connection issues with the eConnector (1520).

Integrated Texting
In the Main Menu (592), click eServices, Texting.

Warning: The eConnector (1520) must be running at all times to track monthly limits and overages. If it is not running, text messages can be sent, but tracking information will be inaccurate and customer replies will not be recorded.
By default, usage information for the current month shows. Use the arrows or calendar below the grid to change the month.
• Click the left or right arrows to move forward/back one month.
• Click the calendar dropdown to select a month using the calendar.
• Click **This Month** to quickly switch to the current month.

Column definitions:
• Default: The default texting clinic is marked with an X. See Set the Default Texting Clinic below.
• Location: The name of the clinic/practice.
• Subscribed: Whether or not the location is signed up for integrated texting.
• Primary Phone Number: The location's texting phone number. The number is based only on the office's country, so obtaining a number with your area code is not guaranteed. It is not possible to select a phone number from a list or alter this number.
• Country Code: Where clinic/practice is located. This determines per message fee.
• Limit: The total monthly limit, in USD, for all locations.
• Sent for Month: The total number of outgoing text messages sent during the currently selected month.
• Sent Charges: The total amount of charges for outgoing texts for the currently selected month.
• Received for Month: The total number of incoming text messages received during the currently selected month.
• Received Charges: The total amount of charges for incoming texts for the currently selected month.

Note: If a location sends more than 250 messages per day, a secondary phone number will be assigned for outgoing messages to prevent the location from being marked as a spam sender by wireless carriers. You will not be charged for this additional number.

**Set the Default Texting Clinic**
When using clinics, only patients assigned to a default clinic will receive text messages, or there must be a default texting clinic. To set a default texting clinic:
1. Select the clinic.
2. Click **Set Default**. X will show in the Default column.

This clinic will be used when patients are not assigned to default clinic.

To remove a default, click **Clear Default**, or select a different clinic default.

**SMS Warning Amount**
In eServices Setup(1509), in the Signup Portal, Integrated Texting(1610) area.

<table>
<thead>
<tr>
<th>Country code</th>
<th>SMS Warning Amount (USD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>USA</td>
<td>$0.04/msg 20</td>
</tr>
</tbody>
</table>

In the **SMS Warning Amount** field, enter a new warning amount.

The Warning Amount is an estimate of how much each location (clinic) would like to spend on outgoing text messages per month. This amount is per clinic and applies to every clinic. Once the amount is reached each month, you will be unable to manually send text messages until the amount is increased or a new billing cycle begins.

Example: If $20 is the amount and there are three clinics, each clinic has an amount of $20, but the total amount will equal $60.

Note: The SMS Warning Amount does not apply to or stop automated eReminders, eConfirmations, or Web Sched Recall text messages.
To change the amount, you must currently be on support.

Note: The eConnector must be running at all times to track messages sent. If it is not running, text messages can be sent, but tracking information will be inaccurate and customer replies will not be recorded.

See eServices Signup(1510).

Integrated Texting Troubleshooting
Below is some general help if you experience issues with Integrated Texting(1610).

Other resources:
• General eServices Troubleshooting(1528)
• eReminder and eConfirmation Troubleshooting(1619)
• Web Sched Troubleshooting(1609)

Problem: Text message status is pending shows in the Texting Box.
• eServices are not working. See eServices General Troubleshooting for steps to fix.

Problem: Patients aren’t receiving text messages.
Suggestions:
• First send yourself a test text message.
• If the message to yourself does not go through, contact support. If it does goes through, send the patient another test message to ensure it wasn’t a temporary issue.
• If the patient still doesn’t receive the message, contact support for further troubleshooting.

Some text messages have a status of failed or I received a text stating “Delivery Failure Receipt.” What do I need to do?
It's likely you tried to send a message to a recipient (patient) with an invalid wireless phone in Edit Patient Information. The common causes for this are:
• Recipient phone is a landline.
• Recipient country code and/or area code are incorrect.
• Recipient country code is not eligible to receive messages from this practice.
• Patient phone number is formatted incorrectly.

To fix this, edit the patient's wireless phone and try again. If you receive these error messages frequently and are unable to fix the issue, please contact support.

Problem: Can’t delete text message commlog.
Information: Commlogs are created whenever a text is sent or received. Sent text commlogs can be deleted, however received text commlogs cannot because they are directly tied to the received text.

Integrated Texting Q and A
How do I get started?
Sign up for Integrated Texting(1610). See eServices Signup(1510).
**Are there character limitations for integrated texting messages?**

- A message segment is 160 characters. Each additional message segment will result in additional per segment charges.
- Carriage returns add two characters.
- The following characters are allowed: a-z, A-Z, 0-9, . , ; : ! ? ( ) ~ = + - _ \ / $ # & %. If other characters are used the message will fail.

**What happens when my message exceeds the message segment limit of 160 characters?**

In the U.S., Puerto Rico, and Canada each additional 160 characters is also charged a fee. This table has been ommitted.

For international message segment limitations, see [International Fees](#).

Note: Non-English language characters may significantly increase the size of text messages and cause charges to vary.

**Can images and videos be sent via text message?**

No, text messages can only contain the characters noted above.

**What if I send a text message to a landline number instead of a mobile number?**

In the U.S. and most other countries, text messages to a landline will be rejected. In Canada, some mobile numbers have been mistakenly marked as landlines. Thus, we allow messages to be sent to all numbers, even if marked as a landline. If the number is a mobile device, the text will be sent and you will be charged. If the number is a true landline, the message will not be sent, but you will still be charged.

**My patients all have Text OK set to ?? . Do I have to manually change them all to Yes in order to send text messages?**

No, you do not have to manually change the status. In [Family Module Preferences](#), uncheck Text Msg OK status, treat ?? as No instead of Yes. All patients with a Text OK status of ?? will receive texts.

**Do I need to be on support to use Integrated Texting?**

You need to be on support to sign up for integrated texting. This will give you access to version updates and support as you begin using the new service. After a brief support period, you can cancel support and continue to use the integrated texting service if you choose, however monthly limits cannot be changed if you are not on support.

**How do I cancel Integrated Texting?**

You must cancel the service using the Signup Portal or by contacting Open Dental. Canceling support will not automatically cancel integrated texting.

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**eReminders**

In the [Main Menu](#), click eServices, eReminder.
eReminders is an eService that sends automated text message and/or email reminders about upcoming appointments. They are intended to be sent a short time before an appointment so patients don’t forget to come.

For a list of supported browsers, see Computer Requirements.

General Steps
1. Create eReminder Rules and select other options. Rules determine when and how an eReminder is sent, and the reminder message.
2. Activate the eReminder service.

Webinar: Automated Messages: eReminders and eConfirmations

Appointment Reminder: Buster is scheduled for 1:30 PM on 11/3/2017 at North Clinic. If you have questions call 1111111111.

eReminder rules determine when reminders are sent, the delivery method, and the message text.

- Note: To send eReminders, the eConnector must already be installed. See eConnector(1520) for easy installation steps.
- When there are multiple clinics, you can create default rules that are used by all or some clinics, or different rules for each clinic. Automation can also be turned on/off per clinic.

Create eReminder Rules
1. Select the clinic and any clinic-specific settings.
   - To create default rules, select Defaults as the clinic, then create the rules.
   - To apply default rules to a clinic, select the clinic, then check Use Defaults.
To create clinic-specific rules, select the clinic, uncheck **Use Defaults**, then create the rules.

To turn on/off automation by clinic, select the clinic, then check/uncheck **Enable Automation for Clinic**.

2. Click Add Reminder or double click an existing rule to edit.

3. **Enable**: By default this is checked, meaning the reminder rule is turned on and active. Uncheck to disable the reminder.

4. **Send Time**: Set time preferences for sending the message.
   - **Days / Hours**: Set how far in advance of the appointment, in hours or days, the eReminder should be sent. Entering 0 for both days and hours will disable the rule without deleting it.
   - **Do not send within ____ of appointment**: Control whether or not messages are sent for short notice appointments (e.g. same day appointments). When values are entered for Days / Hours, eReminders will not be sent when the upcoming appointment time falls within the time period. If both Days and Hours are blank, reminders may be sent up to the appointment time.

Note: The automated eServices schedule also affects send time. See **eServices Misc** (1634). If a reminder is scheduled to be sent before the automated eServices start time, the **Do not send** value is ignored.
5. **Send Order**: Select how the eReminders will be sent.
   - Check **Send All** to send via text message and email, if patient has both options.
   - Or, set a specific delivery method order. The method listed first will be attempted first. If unsuccessful, the second method will be attempted. If that is unsuccessful, the third method will be attempted. Highlight a method, then click the up/down arrows to reorder it. Options include:
     - Preferred Confirm Method: Use the patient's preferred confirmation method to send the message. If Work Phone is selected the program will move to the next send method (Text or Email). See [Edit Patient Information](#62).
     - Text: Send text messages.
     - Email: Send email messages.
   To send text messages, sign up for [Integrated Texting Feature](#). To send emails, set up [Email](#747).

6. **Customize the eReminder text and email message.**
   - **Text Message**: The text used for text messages.
   - **Email Subject and Body**: The first text box is for the subject line. The second text box is for the body of the emails.

To insert data from the database into the message text, use Template Replacement Tags.

- **[ApptDate]**: The date of the appointment.
- **[ApptTime]**: The start time of the appointment.
- **[ApptTimeAskedArrive]**: The time the patient is asked to arrive ([Time Ask to Arrive](#58)).
- **[ClinicName]**: The name of the clinic ([Clinic](#1224)).
- **[ClinicPhone]**: The phone number of the clinic.
- **[EmailDisclaimer]**: This statement includes Practice([931](#931)) or Clinic([1223](#1224)) address and instructions about how to unsubscribe from eService emails (see example below). The statement is only included in emails sent for Web Sched ASAP([1594](#1594)), Web Sched Verify([1606](#1606)), Web Sched Recall([1600](#1600)), eConfirmations([1620](#1620)), eReminders([1613](#1613)), Patient Portal Invites, the Confirmation List([35](#35)), and the Recall List([27](#27)).

**Example:**

This email has been sent to you from:

North Clinic

123 Walrus Way

Portland, OR 97338.

How to unsubscribe:

If you no longer want to receive any email messages from us, simply reply to this email with the word "unsubscribe" in the subject line.

- **[NameF]**: Patient's first name.
- **[PracticeName]**: The practice name ([Practice Setup](#931)).
- **[PracticePhone]**: The practice phone number.
- **[ProvAbbr]**: The abbreviation for the provider the appointment is scheduled with.
- **[ProvName]**: The provider the appointment is scheduled with.

Note: Click [Edit](#) to open the [HTML Email](#) editor and further customize the invite email.

7. **Click OK to save the rule.**

**Note:** When a new appointments is created and the send time for some rules have already passed, the rule closest to the appointment date/time will be used. Example: There are two rules: 7 day and 3 day. A new appointment is created 2 days from now. The 3 day rule will be used since it is closest.

**Aggregated Messages**

When one or more appointments on the same day share a common patient email address and/or wireless phone number, the associated eReminders will be grouped together into one long text message or email.
To customize aggregated messages:

1. On the Edit eReminder Rule window, click Advanced.

2. Change the text message and email templates as needed. See below for a description of each field.

3. Click OK to save and return to the Edit eReminder Rule window.

Note: Clicking Cancel to close the window will also close the Edit eReminder Rule window without saving any settings.
**Template Replacement Tags:** A list of valid template replacement tags that can be used to insert data from the database into the message.

**Aggregated Text Message**
- **SMS Template:** The text and template replacement tags to use for the general aggregated text message. The tag [Appts] will represent each appointment and is required.

  Appointment Reminder:

  \[Appts\]

  If you have questions call [ClinicPhone].

- **SMS Template per Appointment:** The text and template replacement tags to use for each appointment [Appt].

  [NameF] is scheduled for [ApptTime] on [ApptDate] at [ClinicName].

**Aggregated Email Message**
- **Email Subject:** The text to use for the subject line of emails.

  Appointment Reminder

- **Email Template:** The text and template replacement tags to use for the general aggregated email message. The tag [Appts] will represent each appointment and is required.

  Appointment Reminder:

  \[Appts\]

  If you have questions call [ClinicPhone]. Note: Click Edit to open the HTML Email editor and further customize the invite email.

- **Email Template Per Appointment:** The text and template replacement tags to use for each appointment [Appt].

  [NameF] is scheduled for [ApptTime] on [ApptDate] at [ClinicName].

The text message and email templates above would result in the following message:

Appointment Reminder:

Ann is scheduled for 3:45 pm on 3/24/2018 at North Clinic.

Jerry is scheduled for 4:45 pm on 3/24/2018 at North Clinic.

If you have questions call 555-555-5555.

Note: When a patient has multiple appointments on the same day, only their earliest appointment will show in the message.

**Allow eMessages from Appts w/o Clinic**

This is a general option that applies to both eReminders and eConfirmations when the clinic on an appointment is set to none.

- **Checked:** eMessages will be sent to all appointments, even if no clinic is assigned.
- **Unchecked:** Appointments with no clinic will not be sent a message.

**Activate the eReminder Service**

When rules, confirmation status, and automation options are set up correctly, activate the service to begin sending eReminders.
On the Automated eReminders and eConfirmations tab, click Activate eReminders. The button label will toggle to Deactivate eReminders.

Note: To stop all eReminders from sending, click Deactivate eReminders.

Questions and Answers
How can I prevent an eReminder being sent for a specific appointment/patient?
Option 1:
By appointment, apply a Confirmed status that is marked as Don't Send for eReminders. To mark a status as Don't Send:
1. In the Confirmation Statuses grid, double click the appointment confirmation status.
2. On the Edit Definition window under eReminders, check Exclude when sending.

Examples:
- Patient doesn't want to receive automated eReminders at all. Set the Confirmed status for all appointments to a status that won't send.
- Patient has multiple scheduled appointments on the same day (e.g. one with hygienist followed by one with the doctor). Set the Confirmed status of the later appointment to a status that won't send.

Option 2:
By patient as a whole, set the Exclude eConfirms/Reminders setting in the Edit Patient Information. If text or email is selected, the patient will not receive eReminders or eConfirmations via the selected method. Select both to exclude all.

eReminder and eConfirmation Troubleshooting
Below are common questions about eReminders, as well as some troubleshooting steps.

Problem: I have clinics, and my eReminders and eConfirmations are not sending.
Check that you have assigned clinics to patients, appointments, and operators. In addition, in eReminders or eConfirmations, check the option Allow eMessages from Appts w/o Clinic. This will ensure that eMessages are sent for all appointments, even those with no clinic assigned.

Problem: Automated eReminders or eConfirmations aren't sending.
Solution: When a reminder cannot be sent, an error is logged. You can access this log to see which patients did not receive reminders. This can only be accessed on the computer with eConnector installed.
1. Navigate to the C: drive.
2. Open the Program Files(x86) folder, then OpenDental\OpenDentaleConnector\Logger\ConfirmationRequests or AppointmentComm.

These folders are only be available if an error was logged for eConfirmations or eReminders.

Problem: eConfirmations/eReminders don't seem to be sending via text message.
Solution: Go to Setup\Family Insurance\Family Preferences. Review the preference 'Text Msg OK, treat ?? as no instead of Yes'. This is checked by default but you may consider unchecking this preference. This will allow texts sent to all patients except those Marked as 'No' for texting in the Family Module Patient info section.
eConfirmations

In the **Main Menu** (592), click **eServices, eConfirmations**.

![Image](image_url)

**eConfirmations** are automated text message and/or email reminders about upcoming appointments that also allow the patient to e-confirm.

1. **Signup for eConfirmations.** Service fees apply. See [Signing up for eServices](#)(1510).
2. **Create eConfirmation rules.** Rules determine when and how an eConfirmation is sent, and the eConfirmation message. **Note:** To send email reminders you must have an address setup and assigned as Default and WebMail Notify in [Email Setup](#)(747).
3. Go to [Family Module Preferences](#)(637) and choose behavior for patients with a Text Msg OK status of ??.
4. **Select other eConfirmation settings** (confirmation status options, one vs two-click messages, clinic preferences).
5. **Activate the eConfirmation service.**

**Webinar: Automated Messages: eReminders and eConfirmations**

eConfirmation rules determine when eConfirmations are sent, the delivery method, and the message text. You can create an unlimited number of rules.

**Note:** When there are multiple clinics, you can create default rules that are used by all or some clinics, or different rules for each clinic. Automation can also be turned on/off per clinic.

**Create eConfirmation Rules**

1. Select the clinic and any clinic-specific settings.
   - To create default rules, select **Defaults** as the clinic, then create the rules.
To apply default rules to a clinic, select the clinic, then check **Use Defaults**.

To create clinic-specific rules, select the clinic, uncheck **Use Defaults**, then create the rules.

To turn on/off automation by clinic, select the clinic, then check/uncheck **Enable Automation for Clinic**.

2. Click **Add Confirmation** to create a new rule, or double click an existing rule to edit.

3. **Enable**: By default this is checked, meaning the rule is turned on and active. Uncheck to disable the rule.

4. **Send Time**: Set time preferences for sending the message.
   - **Days / Hours**: Set how far in advance of the appointment, in hours or days, the eConfirmation should be sent. Entering 0 for both days and hours will disable the rule without deleting it.
   - **Do not send within ____ of appointment**: Control whether or not messages are sent for short notice appointments (e.g. same day appointments). When values are entered in the Days / Hours, eConfirmations will not be sent when the upcoming appointment time falls within the time period. If both Days and Hours is blank, messages may be sent up to the appointment time.

   - **EmailDisclaimer**: The automated eServices schedule also affects send time. See eServices Setup Miscellaneous Tab (1634). If a
Patients cannot be sent more than one eConfirmation text in the same day.

When a new appointment is created and the send time for some rules have already passed, the rule closest to the appointment date/time will be used. Example: There are two rules: 7 day and 3 day. A new appointment is created 2 days from now. The 3 day rule will be used for the since it is closest.

Send Order: Select how eConfirmations will be sent.

- Check **Send All** to send via text message and email, if patient has both options.
- Or, set a specific delivery method order. The method listed first will be attempted first. If unsuccessful, the second method will be attempted. If that is unsuccessful, the third method will be attempted. Highlight a method, then click the up/down arrows to reorder it. Options include:
  - Preferred ConfirmMethod: Use the patient's preferred confirmation method to send the message. If Work Phone is selected the program will move to the next send method (Text or Email).
  - Text: Send text messages.
  - Email: Send email messages.

To send text messages, sign up for [Integrated Texting](https://www.integratedtexting.com). To send emails, set up email.

5. Customize the eConfirmation message for text messages and/or emails.

- **Text Message:** The text used for text messages.
- **Email Subject and Body:** The subject line and body text used for emails.

To insert data from the database into the message text, use Template Replacement Tags.

- **[ApptDate]:** The date of the appointment.
- **[ApptTime]:** The start time of the appointment.
- **[ApptTimeAskedArrive]:** The time the patient is asked to arrive. Defaults to the appointment time if TimeAskToArrive is not set. See [Time Ask to Arrive](#).
- **[ClinicName]:** The name of the clinic.
- **[ClinicPhone]:** The phone number of the clinic.
- **[ConfirmCode]:** Include the short code C in an integrated text message. Example: Reply [ConfirmCode] to confirm = Reply C to confirm. When patient texts back a C, the appointment confirmation status will change to the Accepted status.
- **[ConfirmURL]:** Creates a URL link the patient can click to confirm their appointment or request a call back.
- **[EmailDisclaimer]:** This statement includes Practice(931) or Clinic(1223) address and instructions about how to unsubscribe from eService emails (see example below). The statement is only included in emails sent for Web Sched ASAP(1594), Web Sched Verify(1606), Web Sched Recall(1600), eConfirmations(1620), eReminders(1613), Patient Portal Invites, the Confirmation List(35), and the Recall List(27).

Example:

This email has been sent to you from:

North Clinic

123 Walrus Way

Portland, OR 97338.

How to unsubscribe:

If you no longer want to receive any email messages from us, simply reply to this email with the word "unsubscribe" in the subject line.

- **[NameF]:** Patient's first name.
- **[PracticeName]:** The practice name.
- **[PracticePhone]:** The practice phone number.
- **[ProvAbbr]:** The abbreviation for the provider the appointment is scheduled with.
- **[ProvName]:** The provider the appointment is scheduled with.

6. Click **OK** to save the rule.
We recommend testing the rule and message prior to sending. Make sure you meet character limitations, that replacement tags work, and that the message appears as intended.

**Aggregated Messages**

When one or more appointments on the same day share a common patient email address and/or wireless phone number, the associated eConfirmations will be grouped together into one long text message or email. If a patient responds to the eConfirmation, it will change the confirmation status for all appointments in the message.

To customize aggregated messages:

1. On the Edit eConfirmation Rule window, click **Advanced**.
2. Change the text message and email templates as needed. See below for a description of each field.

3. Click OK to save and return to the Edit eConfirmation Rule window.

Note: Clicking Cancel to close the window will also close the Edit eConfirmation Rule window without saving any settings.

**Template Replacement Tags**: A list of valid template replacement tags that can be used to insert data from the database into the message.
Aggregated Text Message

- **SMS Template**: The text and template replacement tags to use for the general aggregated text message. The tag [Appts] will represent each appointment and is required. The tag [ConfirmURL] represents the link to the confirmation URL.

Appointment Confirmation:

[Appts]

Goto [ConfirmURL] for confirmation options, or call [ClinicPhone].

- **SMS Template per Appointment**: The text and template replacement tags to use for each appointment [Appt]. [NameF] is scheduled for [ApptTime] on [ApptDate] at [ClinicName].

Aggregated Email Message

- **Email Subject**: The text to use for the subject line of emails.

Appointment Confirmation

- **Email Template**: The text and template replacement tags to use for the general aggregated email message. The tag [Appts] will represent each appointment and is required. The tag [ConfirmURL] represents the link to the confirmation URL.

Appointment Confirmation:

[Appts]

Goto [ConfirmURL] for confirmation options, or call [ClinicPhone].

- **Email Template Per Appointment**: The text and template replacement tags to use for each appointment [Appt]. [NameF] is scheduled for [ApptTime] on [ApptDate] at [ClinicName].

The text message and email templates above would result in the following message:

Appointment Confirmation:

Ann is scheduled for 3:45 pm on 3/24/2018 at North Clinic.

Jerry is scheduled for 4:45 pm on 3/24/2018 at North Clinic.

Goto http://od.ag/c/HQpxDyE for confirmation options, or call 555-555-5555.

Note: When a patient has multiple appointments on the same day, only their earliest appointment will show in the message.

eConfirmation Settings

**Confirmation Status Options**: Each time an eConfirmation is sent, the appointment’s confirmation status can also update automatically. Set the default status to apply in for each circumstance:

- **Sent**: The status applied when an eConfirmation is sent.
  
  Note: If you have set up more than one eConfirmation rule, do not select a default status that is set to *exclude when sending* for eConfirmations.

- **Accepted**: The status applied when a patient confirms the appointment (via the URL link or confirmation code).

- **Not Accepted**: The status applied when a patient replies *Request Phone Call* on the URL link. When a patient requests a call back, an *Alert*(1635) will also notify staff.

- **Failed**: The status applied when the eConfirmation fails to send.

A list of all confirmed statuses shows in the bottom left. Double click on a status to edit its settings. See *Appointment Confirmation Status*(17).
Allow eMessages from Appts w/o Clinic: This is a general option that applies to both eReminders and eConfirmations when the clinic on an appointment is set to none. This is a general option that applies to both eReminders and eConfirmations when the clinic on an appointment is set to none.

- Checked: eMessages will be sent to all appointments, even if no clinic is assigned.
- Unchecked: Appointments with no clinic will not be sent a message.

1 click vs 2 click confirmation: These settings determine whether patient will click on the confirmation link once or twice to confirm the appointment.
- Confirm from link in message (1 click confirmation): When the patient clicks on the link in the eConfirmation message, the appointment will be immediately confirmed.
- Confirm in portal after clicking link (2-click confirmation): This is the default setting. When patient clicks the link in the eConfirmation message, the confirmation portal will open with a list of choices. Patient can opt to confirm or request a callback.

Please Select One

Confirm Appointment

or

Request Phone Call

In response to the following:

Email Message:
Appointment Confirmation

Note: Making changes to this setting will only affect messages sent in the future.

Activate eConfirmations
Once rules, confirmation status, and automation options are set up correctly, activate the service to begin sending eConfirmations.

On the Automated eReminders and eConfirmations tab, click Activate eConfirmations. The button label will toggle to Deactivate eConfirmations.

We recommend testing your eConfirmations and/or eReminders using a test patient with your personal email or wireless number. Schedule an appointment the number of days in advance that matches one of your Rules to verify receipt. This can take a few minutes after the scheduled time of the appointment for it to process. If the message fails to send please contact Open Dental Support for assistance troubleshooting.

Note: To stop using the eConfirmations eService, click Deactivate eConfirmations, then contact Open Dental support to stop charges on your account.
Troubleshooting

eReminder and eConfirmation Troubleshooting(1619)

General eServices Troubleshooting(1528)

What happens when a patient clicks the eConfirmation URL and selects Request Callback?
The appointment status changes to the status selected for Not Accepted and an Alert(1635) in Open Dental will notify staff (those subscribed to the Patient Requested Callback alert).

Note: The alert created when the patient selects Request Callback cannot be deleted but will go away once the appointment status is changed or marked complete.

How do I exclude a patient from eConfirmations?
Set the Exclude eConfirms/Reminders setting in the Edit Patient Information(62). If text or email is selected, the patient will not receive eReminders or eConfirmations via the selected method. Select both to exclude all.

How can I prevent an eConfirmation being sent for a specific appointment/patient?
By appointment, apply a confirmed status that is marked as Don’t Send for eConfirmations. To mark a status as Don’t Send:

1. In the Confirmation Statuses grid, double click the appointment confirmation status.
2. On the Edit Definition window, check Exclude when sending under eConfirmations.

Example: Ignore appointments that are already marked confirmed.

By patient as a whole, set the Exclude eConfirms/Reminders setting in the Edit Patient Information(62). If text or email is selected, the patient will not receive eReminders or eConfirmations via the selected method. Select both to exclude all.

How do I stop the system from automatically updating the appointment confirmation status when an eConfirmation is sent?
To the appointment, apply a confirmed status that is marked as Don’t Change for eConfirmations. To mark a status as Don’t Change:

1. Under Confirmation Statuses, double click the appointment confirmation status.
2. On the Edit Definition window, check Exclude when confirming under eConfirmations.

eClipboard Setup

In the MainMenu(592), click eServices, eClipboard.
To begin using eClipboard, first sign up for the service. eClipboard can be found on the App Store and Google Play. Details on using the app can be seen here: eClipboard: What Patient Sees.

Webinar: eClipboard.

Setup Options
Clinic: Select clinic from the dropdown to create clinic specific settings.

Behavior Rules:
- **Allow self check-in:** If checked, patients are allowed to search their own name, select their appointment and check-in. They will be marked as arrived, and added to the Waiting Room.
- **Allow patients to take self-portrait in mobile app:** If checked, patients will be able to use the device camera to add a Patient Picture from the app. Pictures are immediately imported into Open Dental.
- **Allow patients to fill out forms in mobile app:** If checked, the app will function as a Kiosk where patients will be able to fill out forms defined below while checking in via the app.
- **Add specified forms upon patient arrival:** If checked, forms defined below will be added automatically upon arrival.
- **Show kiosk manager when staff changes patient status to arrived:** If checked, Kiosk Manager will be opened for user who sets patient as arrived to allow forms to be sent to the app.
- **Message to show patients after successful check-in:** Create personalized message to display in app once patient completes check-in.

Specify which forms are added upon patient arrival:
- **Available Sheets (Custom Sheets Only):** Custom sheets available to be added for use in eClipboard. Sheets must have Mobile Layout enabled. Select a sheet in the list and use the blue arrow to move it to the Sheets in Use grid.
- **Sheets In Use:** List of sheets added upon patient arrival if option above has been enabled. Highlight sheet in grid and use blue arrow to remove sheet from use. Double-click to edit Frequency:
Enter number of days before patient will be asked to resubmit this form.

- **Add Custom Sheets:** Click to open *Sheets*(1123) to add more Custom sheets to the list of those available.

**Mobile App Devices:** List of tablets and smartphones that have logged into this database via the iOS or Android eClipboard app. Click in the Enabled row to make devices active for use.

**Device Setup**
Install eClipboard to each device being used in the office. If asked to allow notifications, select *Yes*.

Launch the app and login using the credentials created for eClipboard during *eServices Signup*(1511).

Once logged in, the device will list in the Mobile App Devices grid in the screenshot above. Click in the *Enabled* column on each device to make it active for use.

Lock eClipboard to prevent patients from accessing other areas of the device.
- On Android, enable Pin Windows.
- On iOS, enable Guided Access.

**Appointments**
A patient must have an appointment scheduled for today's date for eClipboard to populate their information. If the appointment is on a different day, or the patient is new to the office, have them go to the front desk. Once they are scheduled for today's date they may use eClipboard.

**eClipboard: What Patient Sees**
On an Android or iOS tablet, launch the *eClipboard*(1627) app.

Before using eClipboard, you must *Signup*(1510) for the service and enable your preferred *eClipboard Settings*(1627). App Login Process is described at the bottom of this page.

Webinar: *eClipboard*.

**Patient Check-in Process**
If *Allow self check-in* is enabled, patients will start by entering their first name, last name, and birthdate. Preferred names will be taken into consideration if they are entered in the [Edit Patient Information](62) window. Once entered, the patient will be asked to confirm the time of their appointment and provider.

*e.g.* Is your appointment at 12:00 PM with Doctor Jones?

Selecting **Yes** will take them to the Check-in Checklist. Selecting **No** will take them back to the Check-in screen.

**Patient Forms**

If *Allow patient to fill out forms in mobile app* is enabled, patients will be presented with a list of forms to fill out. Staff will also be able to send or remove forms from the list from the [Kiosk Manager](1444). This can happen at any time in the eClipboard process as forms will upload to the device in real time.

To automatically add forms, enable *Add specified forms upon patient arrival* then select a frequency for each form.
If manually checking in a patient, enable *Show kiosk manager when staff changes patient status to arrive*. This will prompt the Kiosk Manager to show and send the forms to a device.

Each checklist item will turn into a green checkmark once complete.
Patient Information

First Name
John

Last Name
Smith

Birthdate
7/1/2019

Medications

New Medications
Add +

How did you hear about us?
Email
Text
Internet
Newspaper
Other

Is this your first visit?

What is the reason for your visit?
Tooth ache

Preferred contact method
Text

I consent to treatment today

Your signature is required in order to continue
Please sign

Enter Signature Above The Line

John Smith
Forms use the mobile layout of custom sheets. Patients may fill out each form and sign digitally using the touch screen of the device.

**Patient Photo**

To use the Patient Photo screen, enable *Allow patients to take self-portrait in mobile app*. Even when enabled, patients may skip this step and submit forms anyway.

Patients use the app to capture a self portrait using the tablet's camera for use as a [Patient Picture](#).

**Return Screen**

Once all items are submitted, a message will show requesting the patient return the device. You may customize the message in your eClipboard setup.

Click **Finish** to return to the Check-In screen, or wait 20 seconds and the app will automatically refresh.

To close the app, you will need to enter the password of any Open Dental user. This is to prevent patients from accessing other areas of the device.

**App Login Process**

To begin, login with the User Name and Password you created during the signup process. This will only need to be done each time the app is launched.
eServices Misc

In the **Main Menu** (592), click eServices, Misc.

The Miscellaneous Tab allows you to set the time window for sending automated Web Sched Recall reminders, eReminders, and eConfirmations. It is also a way to access the old Mobile Synch area.

**Automated eServices Schedule**

The automated eServices schedule determines the time window during which automated [Web Sched Recall](1600), [eReminders](1613), and [eConfirmations](1620) can be sent.

- **Start Time**: The earliest a due message can be sent.
- **End Time**: The latest a due message can be sent.

A limited Start Time/End Time (e.g. 7 a.m. - 8 a.m.) will force the eConnector to queue up the messages that would be sent later in the day and instead send within the last few minutes of the run time.

The **eConnector** (1520) must also be running during the time window. Messages due after the End time each day will be sent at the End time. Same day eReminders that are due within one hour of the Start time (or before) will be sent one hour before the appointment, regardless of Start time.
Hints:
- To send messages at all hours of the day, regardless of time, set the Start and End time to the exact same time.
- eReminders sent out same day will follow the rule set (e.g. 3 hour reminder), unless it will break the Start Time. In these cases, it will only send out 1 hour prior to the Start Time (e.g. If the appointments and Start Time are at 8 a.m., the 3 hour reminder will send out at 7 a.m.)
- To preview 24 hour run times, change your workstation clock settings to 24 HR.

Date Format
Select the date format to apply in email and text messages (eReminders, eConfirmations, manual confirmations, Web Sched ASAP messages, ASAP List text messages, Web Sched Recall reminders, Web Sched Notify messages, Patient Portal Invites, and email templates that contain appointment date tags).

If using a Custom date format, use the following information as a guide:
- M = month number without a leading zero
- MM = month number with a leading zero
- MMM = abbreviated month name
- MMMM = full month name
- d = day of month number without a leading zero
- dd = day of month number with a leading zero
- ddd = abbreviated day of week
- dddd = full day of week
- yy = two digit year
- yyyy = four digit year

Show Mobile Synch (old-style)
Click to access the old mobile synch interface. See Mobile Synch Setup(1449).

Alerts
In the Main Menu(592), click Alerts.

The Alert menu option notifies the logged-on user of new alerts they are subscribed to. When there are new, unread alerts, the Alert menu item highlights yellow and indicates the number of active alerts.

Also See:
- Alert Subscription(1113)
- Alert Categories(812)

Hover over an alert to see additional options. The options vary depending on the alert.
- Open...: Open a window to perform an action related to the alert.
- Mark as Read: Mark the alert as read, but do not remove it.
- Delete Alert: Remove the alert. It will no longer show for any user.

This table has been ommitted.

Troubleshooting
If you receive an alert, the OpenDentalService is not running, make sure OpenDentalService.exe is installed in the Service Manager(1412).

When using Clinics(1505), only alerts for the currently selected clinic show, and only when the logged on user is subscribed to the alert category.

**Feature Requests**
The Feature Request system is a unique tool that allows you to vote on features you want in Open Dental.

In the Main Menu(592), click Help, Request Features.

The form will be blank until a search term is entered. Click Search to populate all feature requests.

Every office can vote on requests and submit new requests. The voting process takes time but helps us prioritize requested features. We don't supply estimates on when a feature request might be implemented or guarantee that every request will become a feature.

Below are instructions for voting, submitting new requests, and hints for expediting requests.

**How Feature Requests Work**
Submitted feature requests start with an approval status of New and cannot be voted on yet. We will review it and change the status to Approved.

**Voting Options:** You have 100 points to spread among feature requests however you wish. You'll never lose your points, so allocate them liberally. Once a feature is complete, any votes you spent are available to reuse. You can also remove your votes from a request and allocate them elsewhere at any time.

**Critical Status:** You can mark up to two features Is Critical.

**Pledges:** Pledge money on requests that are extremely important to you. Pledges are not required for feature implementation. Pledges can be changed until we begin implementing that feature (status ofInProgress).

**Weight:** An internal calculation used by Open Dental Headquarters to determine the value of a feature request.

You may see a denial status such as Redundant or NeedsClarification. If you see a denial status, delete your request or make changes to it and click Resubmit. This will set the status back to New, and we will review it again.

**Vote on a Feature Request**
Use the scroll bar to view the list of feature requests. Feature requests do not display in the order they will be implemented. Features you submitted (Mine), voted on (My Votes), or pledged towards will display at the top of the list. By default, features are then sorted by weight, then request number. You can also filter the columns.

Enter the request in Search terms by keyword.
Click Search to view existing related feature requests. To limit the search to requests you created, check **Mine.** To only view requests you voted on, check **My Votes.**

(Optional) Click a column title to filter results. Up and down arrows show ascending or descending order. For example, click Total Votes to sort features by highest votes. Click Total Votes again to sort features by lowest votes.

Double-click a feature to view details.

To allot points, enter a number in Points. Optimally, pledge an amount or mark as critical.

**Submit a New Feature Request**

On the feature request window, confirm that a similar request doesn't already exist.

If your feature doesn't already exist, click Add.
Enter a short description and details for the feature you want. The description and detail fields cannot be edited once the request has been submitted.

Wait for an approval status. When approved, we recommend voting for the feature, marking Is Critical, and pledging.

Click OK to save.

If you need to add further functionality to a feature you have already submitted, create a new feature request.

**Improving Feature Request Visibility**

To increase the chances of your feature request being implemented, use this system to your advantage:

1. Search for your request to determine if it already exists.
2. If not, create your feature request, and vote for it when approved.
3. Mark it critical.
4. Pledge money on the request.
5. Use the [User Forum](#) to promote your feature and get others interested in voting for it.

**Expedite Your Feature Requests**

Some larger offices or corporate clients may wish to pay us to add features they really wish to see implemented. Accepting a quote to expedite a feature will bypass the voting system.

1. Search for your request to determine if it already exists.
2. If not, create your feature request, and vote for it when approved.
3. Send an e-mail to customer.relations@opendental.com to request a quote for your feature. Include the Request ID number in your email.

You will be contacted by a member of Open Dental customer relations staff in regards to your request.

**Query Monitor**

In the [Main Menu](#), click Help, Query Monitor.
The Query Monitor window allows you to view query requests made to the MySQL database server as they execute in real-time. This window is non-modal to allow monitoring during normal use of the program. Activity displayed is only from the instance of Open Dental from which it was launched. It does not allow you to monitor all queries being processed by the MySQL server.

Note: The Query Monitor will not work with a Middle Tier connection.

**Query Feed:** Grid shows details on queries sent to the MySQL server.
- **Command:** Exact SQL query command sent.
- **DateTimeStart:** Recorded date and time of the query.
- **Elapsed:** Amount of time to process the query command.

**Start:** Click to begin monitoring queries.

**Stop:** Click to suspend monitoring queries.

**Log:** Click to save a log of queries captured while monitoring. Monitoring must be stopped to use. Log file is saved to the QueryMonitorLogs folder in the A to Z Folder(826).

**Query Details:** Highlight an entry above to see complete details on the query submitted.
- **Command:** Full text of the query selected above.
- **Start:** Date and time when the selected query started.
- **Stop:** Date and time when the selected query completed execution.
- **Elapsed:** Amount of time the query took to complete.

**Copy:** Copy contents of the Command window from Query Details.

**Update**

In the Main Menu(592), click Help, Update.
Using Version shows your current version of Open Dental and the date the update to that version was done.

To update Open Dental versions, your location must be on support and have a unique registration key.

Recommendations:
- Update to the latest stable version to take advantage of the latest features.
- Set a specific computer to run updates from in Miscellaneous Setup (921), Update Server Name. This can prevent accidental updates and is especially important when using eServices or HL7, or when you have multiple locations.
  - We recommend running updates from the server to avoid possible network permission issues.
  - When using eServices, always update from the computer where the eConnector is installed.
  - When using HL7, always update from HL7 server.

- Note: If using replication, see Replication: Update Open Dental Version for update instructions.
- If you experience an error message when updating, you may need to disable your antivirus software.

Webinar: How to Update Versions

Install an Update (new build, new stable, new beta)
Before updating, the Open Dental program must be shut down on all computers. This process can be completed automatically using the shutdown tool that opens when you click Install.

Setup: Enter your registration keys. Usually you will only do this when you first install the full version of Open Dental. See Update Setup (1643).

Click Check for Updates to check for eligible updates. A list of available downloads will populate.
Click **Install** next to the version you want to install.

**New build for current version:** A minor build update for the currently installed version. Includes all of the latest bug fixes for the version.

**New stable version:** This version has gone through the beta testing phase and is considered stable. It will contain new and enhanced features. If you have already installed the latest stable version, this option will not be available.

**New beta version:** This version will contain the newest features, but will likely have some bugs. It is available to all practices, but should only be installed if you are willing to take a small risk. We recommend updating to the newest build regularly if you choose this option. If you have already installed the latest beta version, this option will not be available.

For users with an active registration key, the most recent versions are always available for install. If you do not have an active registration key (no longer on support), you can only install versions that were available as of the date the key became inactive.

Any announcements associated with the update will show. Read carefully before proceeding.

- **Note:** Once you install and run the update, all other computers will automatically update when the program is first opened so you can easily keep all your computers updated.
- If you update from a computer that is running a higher version of Open Dental than the database (server) it connects to, the server will also update and other workstations connected to the server will update the next time they start Open Dental.
• Usually Open Dental will automatically backup the database during an update as a preventive measure. Large enterprise organizations that update often and have a comprehensive backup strategy can contact Open Dental technical support to disable this process.
• Automatic backups during the update process are generated in the MyISAM format. If you ever need to restore from an automatic backup after a failed update, offices that use InnoDB will need to repeat the DB conversion process.

Update in Progress: If anyone attempts to launch Open Dental during an update, they will receive a notification that an update is in progress. Typically the user should wait a few minutes, then click Try Again.

An Override button will be visible on the computer that started the update or on admin computers listed in FreeDentalConfig.xml. Click to stop the update and launch Open Dental.

View a History of Updates
To view a historical list of version updates (16.1 and greater), click Show Previous Versions on the Update window.

Updates for Enterprise Users
Enterprise users who do not allow normal users to have administrative privileges and prefer to centrally manage all software updates can use the standard Windows solution for pushing updates. Use a Group Policy to enable per machine software assignment. For a tutorial, see the Advanced Installer User Guide. Updates are covered in step 6, "Redeploy an MSI package".

Updates for Foreign (Non-U.S.) Users
Foreign releases of beta versions require additional time for bug testing, so users outside the U.S. may note a delay.

Troubleshooting
When I run Setup.exe, the first screen gives three options of Modify, Repair, and Uninstall instead of notifying me it is updating (e.g. from 5.4.18.0 to 5.4.19.0).
Click cancel and try the download again. It is just trying to reinstall the version you already have installed. You will run into issues like this if you take a copy of your database home. When you run Setup.exe on your home computer, it will try to
update the program, but might not have access to the most recent download. If you switch databases (Choose Database window), it may not be able to locate the Setup.exe depending on Data Paths setup. If you install the update from a disk, you won't even use the window above.

When updating a second computer, I receive the message "The expected version information was not found in this file \"\OpenDentImages\UpdateFiles\Manifest.txt. There is probably a permission issue on that folder which should be fixed."
On the first computer (where the update did work), right click on the Open Dental icon and Run as Administrator. Click Help, Update, then click Setup in the upper left. On the Update Setup window, click Recopy. Return to the second computer and try the update again.

When updating, I receive the message "The remote server returned an error: (403) Forbidden."
Update the Website Path for Updates field to point to https://www.opendental.com/updates/

Update fails and the database becomes corrupt.
Revert back to an older version. Older version setup.exe files are usually located in the OpenDentImages\SetupFiles folder. Follow these steps.
1. Log every workstation out of Open Dental.
2. Stop the MySQL service.
3. Rename the corrupted database (include the version number in the name).
4. Locate the backup made during the update and make a copy of it. Rename the copy with the same name as the original database. If you have trouble renaming the database, you may need to pause or stop backups or antivirus software.
5. Move the renamed database to the original database path.
6. Restart the MySQL service.
7. Uninstall Open Dental.
8. Run the Open Dental setup.exe file for older version.
9. Verify everything is working on server.
10. Log into every workstation. The Open Dental version on the workstation should still be the 'old' version. If not, then repeat steps 7 and 8 on the workstation.

Receive a warning error during an update that you will lose data, with an option to continue or abort.
If you choose to continue and want to retrieve lost data, contact Open Dental support and request an escalation to an engineer.

Update Setup
In the Update(1639) window, click Setup.
Most of these values will not change.

Note: The Setup Security Permission (1118) is required for a user to open this window. The Security Admin Permission (1119) is required to change the registration key or save changes.

**Registration Key:** Click Change to enter a valid registration key supplied by Open Dental (usually in your welcome email.)

**Simultaneously update other databases:** Only for offices that always run multiple databases. For example, multiple dental offices are consolidated in one physical location with a common reception area. In these situations:
1. Pick one main database from which you will always perform updates.
2. In that database, open the Update Setup window, and enter the names of all the other databases.
3. Follow this sequence to perform an update:
   - Use the Shutdown Tool on all databases other than the main database.
   - Update the main database. This locks users out of all databases at once.
   - Open up each of the other databases. Users will be locked out until this is done.

**Show buttons for MSI:** Enterprise users may want to use an OpenDental.msi instead of OpenDental.exe. Check this box to show buttons for msi. When you return to the main Update window, you will see the option to download the msi instead of the exe.

**Update Notification Time:** Start a countdown to an update that shows on all workstations.
1. Click Change.
2. Select the date.
3. Select the estimated update time.
4. Click OK.

The time remaining until the update will show in the title bar of all workstations and will update every 5 seconds.

**Update In:** 6 hours, 43 minutes

The install and download msi buttons will also be disabled. Once the date/time has passed, the countdown will no longer show and buttons will enable again.

**Note:** The update will not automatically occur once the countdown ends. It must still be manually started.

**Recopy:** Click to update the Update Files folder in the A to Z folder with files from the most currently installed version.

**Troubleshooting**

Because of possible redirect issues, using `http://www.open-dent.com/updates/` can result in the following 403 error when trying to update.

**Website Path for Updates:** Change this from `http://www.open-dent.com/updates/` to `http://www.opendental.com/updates/`

After updating the URL you should be able to update again.

**About**

In the **Main Menu** (592), click Help, About.
The About window contains connection, copyright, and license information. The current Open Dental version and the date of the update show at the top.

**Current Connection:**
- Client or Remote Application Machine Name: The name of the client machine or the remote application machine.
- Server Name: The name of the Open Dental server.
- Service Name: The name of the MySQL service.
- Service Version: The version of MySQL that is installed.
- Service Comment: Informational comments about the MySQL version.

Also see:
- Diagnostics(1647)
- View Licenses(1646)

**Licenses**
In the About Window(1645), click View Licenses.
Click each license to view details.

Also See:
- Programming Resources for information on our Open Source license
- CDT(1209)
- Dropbox(831)
- Oracle

Diagnostics
In the About Window(1645), click Diagnostics.
Diagnostics is a tool used by Open Dental support technicians to help gather basic database and connection information for troubleshooting purposes.

**Copy All**: Copies all text.

**Print**: Print all text.

Click **OK** to close.

### Help Feature

The Help Feature allows easy access to the manual and FAQs. It is available for customers on Support.

In **Open Dental** (592), at the top of a window, click the ? icon.

When clicked, the corresponding manual page will open.

If a manual page has FAQs included, they will appear at the bottom of the page.
Main Toolbar
There is a common toolbar at the top of the Open Dental regardless of which Module(1) you are in.

Select Patient(1649): Select patients or create new patient records.

Commlog(1654): A general purpose log of all patient communications.

Email(1656): Click the main button to send an email to the patient. Click the dropdown to send an email to a referral.

Webmail(1672): Send secure WebMails.

Text Message(1675): Click the main button to send a text message to the selected patient. If using Integrated Texting, click the dropdown to open the Text Messaging inbox and view received and/or sent messages. This button is only enabled if text messaging is enabled.

Letter(1678): Click the main button to create a patient letter. Click the dropdown to create a referral letter or to merge letters.

Forms(1690): View, add, or edit electronic patient forms.

Tasks(1695): Send a task about the current patient to a specific task list. Total number of new tasks show as a notification in orange. Click the dropdown to view new tasks for the logged-on user, including task lists the user is subscribed to and task reminders.

Label(1708): Click the main button to create a patient mailing label. Click the dropdown to select other label formats, labels for insurance carriers, and labels for referrals.

Popups(1709): Set up automatic messages that pop up every time you open a patient's record.

Select Patient
In the Main Toolbar(1649), click Select Patient.
The name of the currently selected patient shows in the upper left title bar of Open Dental. Moving between modules does not change the patient.

Double-click on the patient row to select. The patient record will open in whatever module you began in.

By default, only one page of patients lists in the Select Patient grid at once. Names are sorted alphabetically by last name. The columns of information are customizable in Display Fields (900).

**Keyboard**: Click to use the built-in Windows keyboard.

**Search by**: To filter the list, enter criteria in the Search by area. You can search by one or many criteria, and enter information by typing or using the keypad.

- **First Name**: By default this field searches patient first name only. To also search preferred name, see Miscellaneous Setup (921).
- **Billing Type**: Options are defined in Definitions: Billing Types (850).
- **Site**: Options are defined in the Site List (1272).
- **Clinic**: If using Clinics, filter the list to patients who are associated to a specific clinic as well as patients who are unassigned. Patients are associated to clinics when the clinic is their default or if they have any appointments in the clinic. The default selection is the clinic selected in the main menu.
- **Guarantors Only**: Only list guarantors.
- **Hide Inactive Patients**: Exclude patients with a status of Inactive.
- **Show Archived/Deceased/Hidden Clinics**: Show patients that have a status of *Archived* or *Deceased*, or whose default clinic is marked hidden.
- **Show Merged Patients**: Show patients who have been merged into another patient. Option only displays if *Show Archived/Deceased/Hidden Clinics* is checked.

Note: Only full string matches will display, with exact matches listing first. If you search for "cott", only results that start with "cott" will display (e.g. Cotter). Results that include "cott" mid-string will not (e.g. Scott).

**Search**: Use this to see filter results when Refresh while Typing is not selected.

**Get All**: List all patients (more than 30) that meet the search criteria and activate the vertical scrollbar. When this option is clicked, all patients that match the string of characters entered as search criteria (including mid-string characters) will show. Next Visit and/or Last Visit dates will not be visible when all patients are listed.

**Refresh while Typing**: If checked, as you type criteria the patient list will automatically refresh with matching results. The setting affects this workstation only.

**Add New Family**: You must always search for at least patient last name to see if a patient record exists. If it doesn't, you can add a new patient record using one of the following options:

- **Add Pt**: Add a single patient. See [Edit Patient Information](62).
- **Add Many**: Add multiple family members at once. See [Add Family](1652).

Note: Birth dates entered on select patient window automatically carry over when adding new patient(s).

**Select Patient Dropdown**
Another way to select a patient is by clicking the Select Patient dropdown in the Main Toolbar. The last five patients selected will show, as well as all family members associated with the current patient. Click on a name to select.

<table>
<thead>
<tr>
<th>Select Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smith, Fred M</td>
</tr>
<tr>
<td>Stewart, John</td>
</tr>
<tr>
<td>Garcia, Brenda</td>
</tr>
<tr>
<td>Frederic, 'Jake' Jacob</td>
</tr>
<tr>
<td>Johnson, Lisa</td>
</tr>
<tr>
<td>FAMILY</td>
</tr>
<tr>
<td>Smith, Fred M</td>
</tr>
<tr>
<td>Smith, Jill M</td>
</tr>
<tr>
<td>Smith, Jason M</td>
</tr>
<tr>
<td>Smith, Julie M</td>
</tr>
</tbody>
</table>

**Other Options**
- Click on a different family member in the Family module or Account module.
- Click on a patient's appointment.

**Add Patient**
In **Select Patient** (1649), click **Add Pt**.

On the Select Patient window, at a minimum, enter the last name of the new patient and check that a record doesn't already exist.

To add a single patient, click Add Pt to open the **Edit Patient Information** (62) Window. To add multiple family members, click Add Many. See **Add Family** (1652).

First Name, Last Names, and Birth dates (mm/dd/yyyy) entered on select patient window automatically carry over when adding new patient(s).

**Existing Family**

To add a new patient to an existing family:

In the **Family Module** (59), select an existing patient in the family.

In the Toolbar, click Add.

Enter patient details on the Edit Patient Information window.

Click OK to save.

**Add Family**

This is a quick way to add multiple patients for one family all together.

In **Select Patient** (1649), click **Add Many**.
Note: If a family member was already entered, to not use this window. Add additional family members in the Family Module (59) instead.

You can prompt staff to complete certain fields using Required Fields (71) marked with an *.

Each family member is represented by an information column (last name, first name, gender/position, birthdate/age etc). The last three columns are designated for children. If there are more than five family members, add additional members in the Family module. The guarantor is the person who is responsible for the account. To reduce data entry, some guarantor information will automatically populate for other family members.

If a patient added from this window matches a patient that already exists in the database, a popup warning will display asking if you would like to continue. This validation is done by checking first name, last name, and date of birth.

Last Name/First Name: Once you enter the guarantor's last name, the same last name will automatically populate for other family members as you enter first names. Click in the field to edit.

Birthday/Age: Enter the birth date. Age will automatically calculate when you leave the field. Birth dates entered on the select patient window carry over when adding new patient(s). Format birthdate as mm/dd/yyyy.
Insurance 1, 2: If you have entered Insurance Plan 1 and/or 2 information (see below), indicate which plans apply to each family member. Guarantor selections affect other family members.

Providers: Select each patient's primary and secondary provider. Guarantor selections affect other family members.

Email Address: Enter an email address for each patient. When Autofill patient’s email with the guarantor’s when adding many new patients is turned on in Family Module Preferences (637), entering the guarantor’s email address will enter the email for all family members.

Wireless Phone: Enter mobile phone number for each family member.

Text OK: Indicate if patient can receive text messages.
- Yes: Patients can receive text messages.
- No: Patient cannot receive text messages.
- ??: By default means No, patients cannot receive text messages. To instead have it mean Yes, see Family Module Preferences, General tab, Text Msg OK status.

SS#: Enter a social security number for each patient.

Status: Choose a patient status from the list.

Billing Type: Choose a billing type from the dropdown.

Address and Phone: Enter the zip code and the City and State fields will fill in automatically. To speed up data entry, click the dropdown to select from frequently used zip codes.

Address and Phone Notes: These notes can be longer than four lines, but only the first four lines will show in the Family module without scrolling. They will also show in the Unscheduled List, Recall List, and Appointments module.

Referred From: Enter information about a referral using the button. Entered referrals will be added to the Referral List (1268). Double-click the Referred From field to view all referral sources for the selected patient.

Comm: Enter a Commlog (1654) that will show in each family member's progress notes.

Insurance 1/2: If the family is covered by insurance, enter plan information. There are two options:
- Click Pick from List to select the plan from the Insurance Plans (1244).
- If it is a brand new plan, enter the initial plan information. Subscriber, Subscriber ID and Carrier are required if you have selected an Insurance checkbox (1 or 2) for a family member. Click the Subscriber dropdown to select subscriber name. Add additional insurance information in the Family module.

Note: To enter initial plan information from here, the logged in user must have the Insurance Plan Edit permission. If they do not, they can only Pick From List.

Once you leave this window, go to the Family module to change patient information.

Commlog
The Commlog is a general purpose log of all communications with a patient.

In the Main Toolbar (1649), click Commlog.
There are several additional ways to manually start a commlog:
- Edit Appointment window (click Comm)
- Recall List (click Comm)
- Add Family (1652) window (click Comm)

A log of all commlog entries show in the Account Module (150), Chart Module (298), Edit Appointment (20), and Recall List (27).

In some cases, the commlog window may open automatically to prompt an entry after an action:
- Break Appointment (55).
- Changing status on the Recall List.

Types: The options that show are those listed in Definitions: Commlog Types (863). In some areas of Open Dental, a commlog's default type is set based on where the commlog is created. Set the default type in Definitions.
- APPT: The default commlog type when Comm is clicked on the Edit Appointment window. This type will also be highlighted yellow in the Communications Log area, making it easy to see appointment commlogs at a glance.
- RECALL: The default commlog type when commlog entries are entered from the Recall List.
- MISC: The default commlog type when commlog entries are entered via the main toolbar.

Type does not affect sorting of commlogs.
**Mode:** The method of communication.

**Edit Auto Note:** This button only appears if an Auto Note has been used. Click to complete Auto Note that may have been left unfinished.

**Auto Note:** Add **Auto Notes** to the commlog note text.

**Clear:** Clear contents of commlog note.

**Note:** The commlog text. Once a note is added to a new commlog, you must click OK to save or Delete.

Commlog entries support **Electronic Signatures**.

In some cases, a commlog entry is automatically created after an action:

- Sending individual text messages.
- Sending text messages or printing postcards from the Confirmation List.

**Statements:** Every time you print a statement, a commlog entry with a type of Statement Sent is generated automatically and shown as a line item in the patient's account. These entries do not show in the Communications Log list.

**Auto Save:** New commlogs in progress can be set to auto save on a 10 second timer, if a change was made in that time. Auto Save is only available for newly created commlogs.

- The date and time in the window header shows when the commlog was last saved.
- Enable the Commlogs Auto Save preference in Account Module Preferences. With or without the preference, commlogs in progress are automatically saved when Open Dental shuts down unexpectedly (e.g. during an update).

**Email Message Edit**

In the **Main Toolbar**, click Email.
Alternatively, email can also be sent using these methods:

- From the **Email Inbox** (561) (reply to and compose emails).
- From a **Patient Forms** (1690) by clicking **Email**.
- From the **Treatment Plan Module** (283) by clicking **Email TP**.
- Provide a **EHR Summaries of Care** (445) by clicking **by Email**.

When sending, the window is in compose mode. The Sent/Received status will be Neither and the Date/Time will be Unsent.

**From:** Defaults to the default email address in **Email Setup** (747) or the logged-on user's email (if set up, see **Email Address Edit** (599)). Click the button ![...](image) to open a window listing all email address options for this user. Double-click an address to select, or highlight and click **OK**.
Alternatively, enter an email address and alias manually (e.g. If bob@gmail.com is selected in the dropdown, and Sparkly Dental &lt;bob@gmail.com&gt; is entered, the recipient will see Sparkly Dental instead of bob@gmail.com).

Note: Email addresses tied to digital signatures cannot be edited.

**To**: Defaults to the patient's email address on file. If you begin typing a new email, a recommended contact list will populate. You can select from the list, or continue typing the address.

**CC (carbon copy)**: Enter email addresses that will receive a copy of the message. Blank by default.

**BCC (blind carbon copy)**: Enter email addresses that will be sent a copy of the message, but who will not show as a recipient on any other recipient's email copy. Blank by default.

**Signed By**: Only shows if encrypted email has been set up on the local computer for the From email address. Click Sig to see details (see Digital Signatures below).

**Subject**: The subject of the email message.

**Body**: The message text. If an Email Autograph (1661) is associated with the From address, it is inserted by default. If the autograph is associated to multiple email addresses, the autograph listed first is inserted.

To insert an Email Template (1670), select it and click Insert. The template’s subject and message will replace any existing text (including autographs) and associated attachments will be added.

To insert an email autograph, select it and click Insert. The autograph will automatically insert at the end of the email body text.

To edit the message using basic plain text click **Edit Text**.

To edit the message using HTML coding (for images, fonts, etc.) click **Edit HTML**. See HTML Email for more information.

Note: If you have edited a message using Edit HTML, clicking the Edit Text button will switch to using plain text formatting. However, the HTML tags will not be stripped from the message automatically and you may need to delete them before sending.

All messages are permanently saved. They can be viewed in the Email Inbox, Sent Messages tab, and in the Account and Chart modules.

**Delete**: Delete a sent email from Open Dental. It will remain on the mail server, but will not download again. Emails attached to a patient, once deleted, are removed from the Sent Messages tab, yet still visible in the Commlog and Progress Notes. Emails not attached to a patient are permanently removed.

**Save**: Save an email without sending. Saved emails are attached to a patient list in the Chart module and Commlog. If Open Dental shuts down unexpectedly, emails that are in progress are automatically saved.

**Direct Message**: Sends an Encrypted Email. (see Email Encryption Options (1662)) Regular email is not a secure method of sending PHI. Encrypted email must set up for the sender and the recipient must be a trusted source. If you experience issues sending encrypted email, it can be a permission issue. Try running Open Dental as an administrator.

**Send**: Immediately sends an unencrypted message.
Attachments Tab
Attach files to the email. Click + to add an attachment. You will be prompted to locate and select the file.

If images and documents are stored in a local or network folder (see Data Paths Setup(824)), a list of all images in the selected patient's A to Z folder on the local or network folder will display first. Locate the file and click Open to select it.

If images and documents are stored in Dropbox(831), a Select Files window will open listing all images in the selected patient's Dropbox A to Z folder.

Double click a file to select it, or highlight it and click OK.

Click the right arrow to refresh the list.

Click Preview to view a selected file on-screen.

Click Select Local File to search for the file on the local drive.

Show Email Tab
Select where in Open Dental an individual email will show or not show. To show the email in an area, highlight it. To hide the email in the area, deselect it. By default, all areas are selected.
Email Inbox

Appointment Edit: Edit Appointment (20), Communications Log area

Chart Progress Notes: Chart Module (298), Progress Notes

Account Progress Notes: Account Module (150), Progress Notes

Account Comm Log: Account module, Communications Log area

To view emails that have been hidden in all areas, go to the Email Inbox.

Digital Signatures

When sending encrypted email, a digital signature is sent with the message. To view signature details, click Sig.

Email

There are several types of Email Messages (1656) that can be sent and received using Open Dental accessed from the Main Toolbar (1649).
**Regular email**

Send a clear text Email Message to anyone. Receive email in an Email Inbox(561). Enter settings for your email provider in Email Setup(747). This method does not violate HIPAA as long as you don't send protected health information (PHI).

**Encrypted email**

See Email Encryption Options(1662) for more details.

Securely send and receive encrypted email with trusted sources. Open Dental supports two methods of encrypted email. Both methods require that you obtain and install email security certificates. The methods differ in how security certificates are shared.

- **Standard Encrypted Email** (1666): An email address's public key certificates must be manually shared between sender and recipient before messages can be sent or received.
- **Direct Messaging** (1666): An email address's public key certificates for both sender and recipient must be hosted in DNS. Certificates can then be discovered automatically based on the recipient’s domain. Direct is typically used by EHR providers to exchange patient PHI with other providers (e.g. Summaries of Care).

**Secure Web Mail**

See Secure WebMail(1672).

Send and receive secure messages to and from patients using the Patient Portal. Every time a secure web mail message is sent to a patient, an unencrypted email is sent to the patient to notify them a secure message is waiting in the portal. To view the message, they must then log in to the portal.

**Email Autographs**

Use autographs to insert a valediction, doctor name, office name, and/or contact information to the end of an email.

In the Email Message Edit(1656) window, on the left side, is the E-mail Autograph area.

Select an autograph from the list and click Insert. It will be placed at the end of the email body text.

Autographs are listed alphabetically by description. To delete an autograph, click Delete.

**Add or Edit Email Autographs**

Click Add to create a new autograph, or highlight an autograph, then click Edit.
Enter an identifying Description.

(optional) Enter an email address to associate with this autograph. When this email address is the default From address (when Email is clicked), this autograph will automatically insert at the end of the body text.

Enter the autograph text.

Email Encryption Options

Sending and receiving encrypted Email requires both sender and recipient to share public key security certificates (also known as digital signatures). This verifies that sender and recipient are trusted sources. Open Dental supports Standard Encrypted Email and Direct messaging. Both methods require that you obtain an Email Certificate and Install Private and Public Keys on a Workstation.

Note: Setting up encrypted email in Open Dental is similar to setting it up in Microsoft Outlook and Thunderbird. This table has been ommitted.

**Standard Encrypted Email**

Standard encrypted email is a secure method of exchanging email with trusted sources. Before encrypted email can be exchanged using Open Dental:

- Email must be setup. Email security certificates must be purchased and installed on workstations.
- Both sender and recipient must manually share public key certificates by exchanging digitally signed messages.

See [Email Encryption Setup](1666).

How it works:

1. In Open Dental, Provider A sends a clear text, unencrypted email to Provider B that contains Provider A's public key. To verify the public key is attached to the email, check the Signed By field on the Edit Email Window. It should contain Provider A's email address.
2. Provider B opens the unencrypted email and adds Provider A as a trusted source. In most email programs (e.g. Microsoft Outlook) there will be a notification in the email that the user can click to add a trusted source.
3. Provider B replies with an email that contains their public key (digital signature).
4. In Open Dental, Provider A opens the Email Inbox. Provider B's email message will have 'N' in the Sig column. Click the N to add Provider B's public key to the list of trusted sources on the workstation.
5. Provider A can now exchange encrypted email with Provider B.

The certificate cache is always checked when sending. If a certificate expires, you will need to repeat the steps above with the recipient.

**Direct Messaging**
Direct messaging is a method of encrypted email that is intended to simplify the discovery of public key security certificates. Public key certificates are hosted in DNS so they can be discovered automatically using the domain part of the recipient's email address. Direct is used primarily by EHR providers to exchange clinical healthcare data securely with other providers.

Before Direct messages can be sent using Open Dental:
- Email must be setup.
- Email security certificates must be purchased and installed on workstations.
- Public key certificates must be installed on a hosting server for both sender and recipient.

See Email Direct Encryption(1666).

How it works:
1. Both Provider A and Provider B install email security certificates on workstations and host public key certificates in DNS.
2. Provider A attempts to send an encrypted email to Provider B. A query automatically goes out to discover Provider B's public key certificate. When successfully found, the encrypted email is sent to Provider B.
3. Provider B receives the email, and if needed, adds Provider A's public key certificate to his list of trusted sources.

Direct messages can be sent to a provider who does not use Direct (e.g. a non-EHR provider). The receiving provider must become a trusted source by obtaining a digital signature and setting it up on their system. See Email Certificate Outlook(1663) for instructions on how to create and setup a digital signature in Microsoft Outlook.

**Email Certificate Outlook**

When you send an Encrypted Email(1662), the email address receiving the email is also required to have a secure digital ID (email security certificate). The digital ID verifies that a receiver is a trusted source. Any provider can become a trusted source by obtaining a digital ID and setting it up on their system. These steps explain how to obtain, then import a digital ID into Microsoft Outlook 2013 so that providers can receive encrypted email messages.

1. Obtain a digital ID (Email Certificate(749)) from a Certificate Authority (e.g. Comodo (https://www.comodo.com/home/email-security/free-email-certificate.php)).
2. In Microsoft Outlook 2013, click File, Options, Trust Center, Trust Center Settings..., Email Security.
3. Check two options:
   - Add digital signature to outgoing messages.
   - Send clear text signed message when sending signed messages

4. Under Digital IDs, click Import/Export...
5. Click OK.

6. Click OK.

7. Send a clear text test email to the provider.

Note: Instructions may be different for other versions of Outlook, even though it has supported email signatures and encryption for many years.
Email Direct Encryption

Direct messaging is a method of Encrypted Email(1662) used by EHR providers to exchange patient PHI with other providers (e.g. summaries of care). It is intended to automate the discovery of public security certificates so that messages can be encrypted and sent directly to trusted recipients. For more information about the Direct project, see http://www.directproject.org.

Requirements:
- Open Dental version 14.2 or greater.
- You must have an email address associated with a domain name you own (gmail.com will not work).
- The email address must be associated with an email security certificate. You need one certificate per Direct email address. For EHR, each provider in a practice is not required to have their own email address.
- The email certificate's public and private keys must be installed on each workstation that will receive encrypted email.
- Public keys for both sender and recipient must be hosted in DNS so they can be discovered based on the recipient's domain.

If you do not want to setup Direct messaging in Open Dental, another option is to contract with a Health Information Service Provider (HISP). A HISP performs authentication, encryption, and trust verification on your behalf. To send summaries of care, export the documents, then use the HISP mail client to send. The downside to this option is that you may have to get a new email address supplied by the HISP and it is more expensive.

Sending Direct Messages:
1. Enter the email settings and set the email address as the Default email address in the Email Setup(747).
2. Obtain an Email Certificate(749) associated with the email address.
3. Install public and private keys on workstations that will receive the direct email. See Email Certificate Install(761).
4. Install the public certificate on a hosting server. You can host it with Open Dental (see Email Certificate Hosting(759)) or host it yourself. Each time a certificate expires, you will need to purchase a new certificate, and, if hosting the certificate on Open Dental's server, re-register the certificate.

Receiving Direct Messages: To receive direct messages, you must also modify each domain that will be used to receive direct messages. It usually takes 30 - 60 minutes before changes are recognized, but can take up to 48 hours.
1. Purchase an internet domain name if you do not already have one. GoDaddy is recommended because that is all we have tested. Other domain providers are allowed, but have not been tested.
2. Login to your domain provider website and launch the domain.
3. Create a new host name under the Host Names section. Use host certdns2 with IP address 198.0.40.74 (the Open Dental certificate server). Use the IP address for another certificate host or HISP if you wish.
4. Add a new name server record under the Nameservers section. If your domain name is yourdomain.com, then you need to add the name server certdns.yourdomain.com. This name server should be listed last in the Nameservers section, since it is the lowest priority for name look up.

Become a Trusted Source: To send secure messages to a provider who does not use Direct (e.g. a non-EHR provider), the receiving provider must become a trusted source by obtaining a digital signature and setting it up on their system. See Email Certificate Outlook(1663) for instructions on how to create and setup a digital signature in Microsoft Outlook.

Email Encryption Setup

Standard encrypted email(1662) is a secure method of exchanging email with trusted sources. It requires that both parties share public security certificates by exchanging digitally signed messages.

Requirements:
- Open Dental version 15.1 or greater.
- You must have an email address.
- The email address must be associated with an email security certificate.
- The email certificate's public and private keys must be installed on each workstation that will receive encrypted email.
- Both sender and recipient must manually share public key certificates by exchanging digitally signed messages.

**Open Dental Set up**
Enter email settings in [Email Setup](747).

Obtain [Email Certificate](749).

Install public and private keys on workstations. See [Email Certificate Install](761).

For each person you want to exchange encrypted email with, share public key certificates by sending digitally signed messages.

1. In Open Dental, send a clear text, unencrypted email that contains your public key to the person you want to send the encrypted email to. You will know the email contains the public key if the Signed By field on the Edit Email Message window contains your email address ([Email Message Edit](1656)).
2. The recipient will open the unencrypted email and add your public key as a trusted source. In most email programs (e.g. Microsoft Outlook) there will be a notification in the email that the user can click to add a trusted source.
3. The recipient will send you an email that has their public key (digital signature).
4. In the Email Inbox, locate the sent message. It will have an N in the Sig column. Click the N to add the recipient's public key to the list of trusted sources on the workstation.

Now encrypted email can be exchanged with the recipient.

The certificate cache is always checked when sending. If a certificate expires, you will need to repeat the steps above with the recipient.

To receive encrypted email, security certificates for your email address must be installed on workstations that will receive the email.

To send encrypted email, the email recipient must have encrypted email set up and have shared their public key with you.

Trust of Security Certificates are computer-specific. If you send an email from the computer you use as your [Email Inbox](561) (Computer Name to Receive New Email From in General Email Settings), every time you send email, the recipient is added to your trusted list automatically. If you receive a message from an unknown recipient that is not in your trusted list, when you open email and decrypt a message, you will be prompted to add the recipient to your trusted list.

Direct messaging is a method of encrypted email that is intended to simplify the discovery of public key certificates, but additional setup is required. See [Email Direct Encryption](1666).

**Email Errors**
If you experience errors when trying to [Send Email](1656), the information below may be helpful.

The most common reason for email errors is incorrect information entered in [Email Setup](747). If sending email fails, follow these general steps:
- Verify the username, password, server, and port information is entered correctly. Username should be your full email address (e.g. john@email.com).
- Check your internet connection.
- If you can send emails outside of Open Dental, your anti-virus software may be blocking emails. To test this, disable anti-virus and try again. You may need to add an exception for OpenDental.exe.

Vendor specific issues:
• Gmail: Substitute email addresses are not allowed. If your Gmail account uses a second password verification, you cannot send email in Open Dental.

**Email Settings by Host**
We have gathered settings for some email hosts. These settings may change at any time so always rely on the settings provided by your vendor. This table has been omitted.

**Specific Errors &amp; Solutions**
If you receive any of the following errors, it means the username and/or password entered in General Email Settings is invalid.

- Authentication Failed
- Mailbox unavailable. The server response was: 5.7.3 Requested action aborted: user not authenticated.
- Mailbox Unavailable. The server response was: #5.1.0 Authentication required.
- Bad sequence of commands. The server response was: you must authenticate first (#5.5.1).

**Error: Mailbox Unavailable. The server responses was: #5.1.0 Address rejected.**
Solution 1: Patient's email address is invalid. Send a test email to yourself to verify the message is only when using the patient's email address.
Solution 2: If sending from a new email address, check your inbox and open another email. This may activate the email address. Send another test to check.

**Error: The operation has timed out.**
Solution: Do some research and find out what port your email provider recommends, then try it. For example, for Gmail smtp.gmail.com with SSL, port 465 has worked for sending emails with attachments.

**Error: All confirmation emails failed.**
Solution: This can happen if the subject line of the email mistakenly includes the body of the message. Check Setup Recall(632) to make sure the subject line has a reasonable amount of words.

**Error: Mailbox name not allowed. The server response was: sorry, that domain isn't in my list of allowed rcpthosts.**
Solutions:
- Make sure the username and password are correctly entered. Verify it works on the email host's website.
- The remote mail server may not like the email address of sender. Make sure it is the same email as entered for the username.
- Something on the server has changed (e.g. the proxy or white list) or a new anti-virus software is acting like the domain is dangerous.
- The email host may have marked the address as spam. Create a new email address and see if it works.

**Error: The SMTP server requires a secure connection or the client was not authenticated. The server response was: 5.7.0 Must issue a STARTTLS command first. x31sm2514409ana.9**
Error: Command not implemented. The server response was :5.5.41. Unrecognized command. z28sm22907yhn.7
Solution: In Email Setup, check the SSL box. Another possibility is to verify the password is correct. Some computers connected to the network and using the same email setup in Open Dental may be able to still use the email service if this box is unchecked.

**Error: The remote certificate is invalid according to the validation procedure.**
Solution: In Email Setup, uncheck the SSL box.

**Error: Service not available, closing transmission channel.**
Solution 1: Try a different outgoing port.
Solution 2: It could be caused by your antivirus software.

**Error: Open Dental appears to have successfully sent email, but recipient never receives it.**
Solution: Your mail server may block outgoing mail if too many emails are sent at one time. Contact your provider to change the setting.

Error: Email fails to send and an error message reads: "Transaction failed. The server response was: 5.7.1 &lt;yourpatient@some server.com&gt;: Recipient address rejected: Access denied.
Solution: SMTP server will not relay the message; this is usually due to an incorrect password.

Error: Keyset does not exist.
Solution: Run Open Dental as administrator.

Error: Mailbox unavailable. The server response was: (WS-SVR) [123.123.123.123]:12345 is currently not permitted to relay.
Solution: Contact your email domain provider and have them allow the relay from Open Dental.

Error: Error retrieving email messages: The stream used to retrieve responses from was closed.
Solution: Check your incoming email settings in Email Setup.

Error: Error retrieving email messages: The handshake failed due to an unexpected packet format.
Solution: This error can happen if your email address is not configured properly. Specifically, if your email account uses SSL and you do not have the SSL option enabled, or if you have SSL enabled and your email account does not use SSL. See Email Setup.

Problem: In the Email Inbox or Progress Notes, email preview and message is showing in HTML code.
Solution: This means the email was sent using Rich Text/HTML format instead of Plain Text.

Problem: An incoming encrypted message is not decrypted.
Solution: This happens when decryption fails. Usually decryption happens automatically when the message is received. However, if the email is from an address with a security certificate that is not trusted, your private decryption key is not installed on the local computer, or the encryption is not in the correct format, decryption fails. To see encrypted email options, see Email Encryption Options (1662). To add a certificate to your trusted list or retry decryption, see Email Inbox (561), When Decryption Fails.

Yahoo
Error: The transport failed to connect to the server
Solution: Set the SMTP server to: plus.smtp.mail.yahoo.com.

Error: The message could not be sent to the SMTP server. The transport error code was 0x80040217. The server response was not available
Solution: Yahoo is blocking “less secure” 3rd party applications. Create an App password for use with Open Dental.

Gmail
Gmail outgoing encrypted emails will only work over port 587 with SSL enabled.

Error: Command not implemented. The server response was:5.5.1 Unrecognized command, s45sm17366386yhk.22 - gsmtp
Solution: In General Email Settings, change port 587 to 465.

Error: The message could not be sent to the SMTP server. The transport error code was 0x80040217. The server response was not available
Solution 1: Verify user name and password (e.g. must include @gmail.com)
Solution 2: Google is blocking account access from "less secure" 3rd party applications. See https://support.google.com/accounts/answer/6010255?hl=en. Google does not identify exactly what makes an application less secure, but offers two solutions: use the Gmail application instead or allow less secure apps. To allow less secure apps, log into Gmail. You should receive a message related to unauthorized access. Follow the instructions in the message to change your Gmail account settings to "Allow less secure apps".

Error: The SMTP server requires a secure connection or the client was not authenticated. The server response was: 5.5.1 Authentication Required.
Solution 1: Enable less secure apps if you are using a regular Gmail account.
Solution 2: Change password to a more secure option.
Note: Gmail managed domains may not allow enabling of less secure apps. The domain administrator must login and give domain users the right to enable less secure apps.

**Office 365**

**Error:** The SMTP server requires a secure connection or the client was not authenticated. The server response was: 5.7.57 SMTP; Client was not authenticated to send anonymous mail during MAIL FROM.

**Solution:** Most likely, Office 365 needs you to create a new password. Log in to the Office 365 portal (https://login.microsoftonline.com/). You will be prompted to change the password. Once the password is changed and reflected in Open Dental, email should work.

Alternatively: If the above does not solve the problem, try removing the Sender Address. Leaving this entry blank may allow the client to connect.

**Outlook**

**When trying to send emails in Open Dental using Outlook.com, receive Error: 5.7.3 Requested action aborted: user not authenticated.**

Check your inbox for an email requesting permission to use Open Dental to send emails through Outlook.com. Click the link in the email to activate Open Dental and allowing sending emails.

**Televox**

**Error:** Service not available, Not able to send message:

**Solution:** Use Port 587.

**Prosites**

**Error:** The message could not be sent to the SMTP server. The transport error code was 0x800ccc6a. The server response was 451.

**Solution:** Update to the most recent version of Open Dental.

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**Email Templates**

In **Email Message Edit** (1656), on the left, is the Email Template area.

![Email Template](image)

Templates can be used for frequently sent email messages that have similar content. Select a template and click **Insert**. The template’s subject and message will replace any existing text.

Templates are listed alphabetically. To delete a template, select in the list and click **Delete**.

**Add or Edit Email Templates**
Click **Add** to create a new template, or click **Edit** to edit an existing template.

**Description**: Enter the template name. It can differ from the email subject.

**Subject**: Enter the subject of the email.

**Body**: Enter the body message.

**Attach**: Click to attach images or files to the template. Select the file, then click Open. Attachments will list in the box.

Double-click an attachment to preview it.

Right-click an attachment to open, rename, or remove it.

**Edit Text**: Used to edit text in body after HTML template has been applied to email.

**Edit HTML**: Add HTML formatting to email template. See [HTML Email](#) for details on use, including the option to edit Raw HTML to further customize templates.

**Subject Fields / Body Fields**: Insert replacement fields into the Subject or Body. Message replacement fields pull information from the database to insert into the message (e.g. insert `[ApptDate]` to automatically insert appointment date).

You may also manually type the replacement (e.g. `[LName]`), but make sure it exactly matches the field name. They are case-sensitive.

Position the cursor to where you want to insert a field, then double-click an item from the list. Fields in red text cannot be inserted.
Click **OK** to save the template.

**WebMail**

Select the patient or their **Authorized Representatives** (1579). In the **Main Toolbar** (1649), click WebMail.
Any user can compose a WebMail, but only a provider can send a WebMail. To set up WebMail, see Setup the Patient Portal (1555).

Patient must have the following entered on the Edit Patient Information (62) before a WebMail can be sent:

- Email address
- Primary Provider

**Regarding Patient:** Verify who the message is about. Click the dropdown to select a different family member.

**From:** Verify the From provider. By default it is the patient's primary provider. Click [...] to change.

Enter a **Subject** and a **Message** (required).

To include an attachment (e.g. a clinical summary), click **Attach**. You will be prompted to locate and select the file.

- If images and documents are stored in a local or network folder (see Paths (824)), a list of all images in the selected patient's A to Z folder on the local or network folder will display first. Locate the file and click **Open** to select it.
- If images and documents are stored in Dropbox (831), a Select Files window will open listing all images in the selected patient's Dropbox A to Z folder.
Double click a file to select it, or highlight it and click OK.
Click the right arrow to refresh the list.
Click Preview to view a selected file on-screen.
Click Select Local File to search for the file on the local drive.

Click Send. If the From provider is logged-on to Open Dental, the message will be sent. If another user is logged-on, the provider's password is required. Enter the password, then click OK.

Once sent, the secure message is sent to the patient portal and an email notification is sent to the patient.

Preview Messages
To preview the email notification (not secure) and the secure WebMail, click the Preview Button on the WebMail Message Edit window.

Text Message
In the Main Toolbar(1649), click Text.

General text messages can be sent from Open Dental to both patients and non-patients. Before sending, first sign up for Integrated Texting(1610) and set monthly limits.

If a patient's Text OK setting is currently No, a message will prompt you to change the setting to Yes. Click Yes to change the setting and proceed.
Select Patient or Another Person.

If patient, verify the patient name and number. To select a different patient, click Find. Phone number automatically populates with the patient's wireless phone number. If another person, enter the wireless phone number.

Enter the text message.
- For character limitations and message segment details, see Integrated Texting Q and A(1612).
- Right click to insert the today's date or Quick Paste Notes(1088).

Click Send.

A commlog entry is automatically generated for text messages sent to a patient. Set the default commlog type for text messages in Definitions: Commlog Types(863).

Messages can also be sent from the Text Messaging Mailbox(1676).

If the monthly texting limit is reached, you will be prompted to increase the limit. See SMS Warning Amount(1611).

- Note: Before sending a text message to a patient, enter their wireless number on the Edit Patient Information(62) and set their Text OK status to Yes.
- Text messages are not a secure method of sending PHI.

Text Messaging Mailbox

In the MainMenu(592), click the Text(1675) dropdown. Select an option.
Outgoing and incoming Text Messages can be viewed in the text messaging inbox. From here you can also reply, block numbers, and attach messages to patients.

- **Text Messages All**: View all sent and received messages.
- **Text Messages Received**: View received messages only. An orange notification shows in the toolbar when you have unread text messages.
- **Text Messages Sent**: View sent messages only.

Up to 100 messages display at a time. When there are more than 100 messages, use the navigation arrows above the grid to scroll through pages. Bold messages indicate unread messages. Click on a row to view the conversation thread on the right.

**Group Messages By:**
- **Patient**: Show one row per patient.
- **PhoneNumber**: Groups messages by number and displays all patient that share the number.
- **None**: Show every message.

To filter results, select a filter option then click Refresh to update.
- **Date From/To**: Show text messages for a specific date range.
- **Patient**: Filter by patient.
  - **Current**: Show texts for the patient currently selected in Open Dental. If patient is part of a family, the guarantor is selected.
  - **Find**: Select a different patient.
  - **All**: Show texts from all patients.
- **Hidden/Received/Sent**: Show hidden, received, and/or sent messages.
- **Clinic**: Filter by clinic.
Right-click on a text message for other options. The options available vary depending on whether you are grouping by patient or by date.

- **Change Pat**: Change the patient attached to a received message.
- **Mark Read/Unread**: Change the status of a received message.
- **Hide/Unhide**: Hide or show the message in the list. Text messages cannot be deleted.
- **Go to Patient**: Make the selected patient active.
- **Block Number**: Block incoming text messages from specific mobile numbers.

If a message has a failed status, see [Integrated Texting Troubleshooting](1612) to troubleshoot why.

**Attach Messages to Patients**
Messages are automatically linked to a patient when phone numbers are an exact match.

- If multiple family members have matching numbers, it will attach to the guarantor.
- If multiple patients across two or more families have the same number, or there is no patient with a matching number, the patient will be **Unassigned**.
- If there are multiple phone number matches, `#Phone Matches` indicates how many patients have a matching phone number.

To manually attach a message to a patient, right click the message and select Change Pat.

**Block a Number**
To block incoming text messages from a specific mobile number, right click on the text message, then click Block Number. The sender will see the text message as delivered, but it will not appear in Open Dental. Blocked messages cannot be recovered.

**Reply to a Text Message**
To quickly send a text message in response to a received message:
1. Highlight the message.
2. Enter the text message in the text box on the lower right.
3. Click Send.

If the monthly texting limit is reached, you will be prompted to increase the limit. See [SMS Warning Amount](1611).

**Letter**
In the [Main Toolbar](1649), click Letter.
Before creating or sending a patient letter, set up at least one custom Patient Letter sheet. See Patient Letter Layout(1172). Sent letters can be viewed in the patient's Chart Module, and Account Module.

A list of custom sheets that have a type of PatientLetter will show. Double click a letter to select and open it to fill out.

Below is a copy of the internal Patient Letter Sheet. The default text is defined in the custom sheet. Click on text, then type to edit it. Letter text indicates an area for the letter content.
Happy Valley Office  
5216 S Welcome Way  
Happy Valley, OR 85118

Roger Ames  
124 Cedar Way  
Salem, OR 97302

Thursday, 10/10/2013  

Dear Roger:  
  letter text

Sincerely,  

Jane Smith

To send the letter, click Print/Email.
• By default, if an email is already entered for the patient on the Edit Patient Information (62), Email to patient will be checked, the email will show, and Paper copy will be set to 0.
• If no email is entered for the patient, the Paper copy default is 1. This value can be manually changed.

Click OK to send.

Referral Letter
In the Main Toolbar (1649), click the Letter (1678) dropdown.

All attached referrals will list under Referrals:. Select the referral name.
A list of custom Sheets with a Type of referral letter will show.

Note:
To create or send a referral letter, you must first complete the following steps:
- Set up at least one custom referral letter sheet. See Referral Letter Layout.
- For the patient, attach the referral in the Family Module (Referrals).

Double-click a letter to open and fill out. Below is a copy of the internal Referral Letter. The default text is defined in the custom sheet. Click on text, then type to edit it. Letter text indicates an area for the letter content.
To send the letter, click Print/Email.
• By default, if an email is already entered for the referral on the Edit Referral window (Referral List(1268)), Email to referral will be checked, the email will show, and Paper copy will be set to 1.
• If an email is entered for the patient, it will also show, but the option will not be checked.
• If no email is entered for a referral, the Paper copy default is 2. This value can be manually changed.

Click OK.

Sent letters can be viewed in the patient's Chart module, Progress Notes and Account module.

If a referral letter contains a procedure grid or tooth chart, it will be saved as a PDF in the Images module.

**Letter Merge**

Letter Merge allows users to create a Word document for a single patient only.

In the Main Toolbar(1649), click the Letter(1678). Select Merge.
Note: Letter Merge only works with Microsoft Word 2002 or later. Consider using the internal Sheets (1123) function for a more updated option for patient letters. Sheets can be used for any patient letter or form and can be customized within Open Dental.

**Edit Categories**: Open Definitions: Letter Merge Cats (875) to create letter categories and set the category order.

Highlight a category to place the letter into and click **Add**.
Enter template information:

- **Description**: Enter the letter name.
- **Letter Merge Path**: Displays the path where letters are stored. Click **Edit Paths** to change the location. A file location must already exist before one can be selected.
- **Template File Name**: Enter the name of the file you are creating or editing.
  - Click **Browse** to copy an existing letter.
  - Click **New** to create a new letter.
- **Category**: Select the category to show the letter in.
- **Save to Image Folder**: Save copy of letter to patient’s selected image folder.
- **Patient Fields**: Select the patient fields to merge into the letter. (e.g. Patient Last Name, Address, Email, etc.).
- **Referred From**: Select the referral information to merge into the letter.
- **Other**: Select additional information to merge into the letter.

Click OK to open Word.

Close Word as it only created a blank template.

In the main Letter Merge window, highlight your letter and click **Edit Template**. This opens your blank template, creates a data file with one row, and attaches the data file to the template as a data source.

Open Word again.
- In the main menu, click Mailings, then Start Mail Merge, Letters.
• In the main menu, click Select Recipients, Use an Existing List.
• Browse to your Letter Merge path. Select the Data Source you wish to use.
• Type your letter. Any place where you want a merge field, click Insert Merge Fields.

From here, you can insert fields, set up address fields using the Match Fields button, etc.
• Save your template and return to Open Dental. You can return here anytime to further edit your template, add more fields, etc.

In Open Dental, create the letter from the Letter Merge window. There are four options listed in the Create area.
• **Data File**: Create a data file only.
• **View Data**: View the data file only.
• **Print**: Print the full letter.
• **Preview**: Preview the full letter.
• **Image Folder**: Informational only. View the image folder this letter will save to. Make changes to the default save folder by double clicking the letter to open the Edit Letter Merge window.

Note: Keep in mind this is a merge letter for only one patient, so the data file will always have only one row of data.

**Troubleshooting**
If you ever see this error: "Word cannot start the converter mswrd632It is due to a recent Microsoft security update", the fix is located here: [http://support.microsoft.com/kb/973904](http://support.microsoft.com/kb/973904).

**Mail Merge in Word**
These steps are provided as a courtesy as an alternative to Letter(1678). Open Dental support technicians do not assist with Microsoft Mail Merges.

If you use Word and you need to do a mail merge, you have some different choices. For a single letter, see Letter Merge(1684). But if you are merging letters for multiple patients than you can either do a query and export the result, or you can link directly to the database.

**Query Export**
You can do a query or patient report from within Open Dental and export the resulting table. It will normally be saved as a text file in your OpenDentalExports folder on your local C:\ drive. The first row of the text file will contain the names of the columns, and the fields are separated by tabs. This makes it very easy to open in Word. There are a couple of places where you can select the data source in Word. If you are in the Mail Merge Wizard, in step 3, choose select a different list. This is one way to bring up the Select Data Source dialog:
Find your OpenDentalExports folder in the file list, and click on the name of the text file that you exported from Open Dental. When the preview comes up, simply click OK. You will now have a list which you can further filter, sort, and select from.

Click on the arrows at the tops of each column for more advanced options. See the Word manual if you need help setting up your letters.

**Direct Link**

Another way to use the data is to directly link to the database. You would not normally need to do this since the text export is simpler, but here are instructions in case you need to. First, set up the ODBC data source on the computer where you want to access the data. Then, open Word and open the Select Data Source dialog as shown above. Select New Source at the bottom.
Select Other/Advanced, and click Next.

Select OpenDental from the data source list and enter the username and password. You can click Test Connection to verify that you have a good connection. Select the table you want from the list and then select the new data source you have created. You will now have a list which you can further filter, sort, and select from, just as in the text import section.
Patient Forms
In the Main Toolbar(1649), click Forms.

Patient Forms are types of Sheets(1123) that patients can complete electronically, such as registration forms, HIPAA forms, financial agreements, and medical histories. If a form uses Input Fields(1135), entered data can be imported into the database.

Patients can complete the forms in one of the following ways:
- Directly in the form (e.g. on the operatory computer, on a tablet, etc.)
- Kiosk Manager(1444).
- Online using an internet browser.
- On paper, then scanned into the Images module.
- eClipboard

Any Patient Forms or Medical Histories already generated for the patient will show in this window. Images, pdf's, or other files that are in an Images category marked with a usage of Show in Patient Forms will also show.

Double-click on a row to view the document or fill it out in the Fill Sheet(1152) window. From there, you can print it, email it, have the patient fill it out, or send it to the patient's list of forms

Setup: Click Setup in the upper left corner, then select a menu option.
- Sheets: Go to Sheets(1123) to customize Patient Forms(1171), Medical Histories(1165), or Consent Forms(1156).
- Image Categories: Opens the Definitions window with Image Categories selected (Definitions: Image Categories(869)). If you want items in an Images module category to show as options in the Patient Forms and Medical Histories list, set it here. Double click on the category, then check the Show in Patient Forms box.
- Options: Check the box to show Consent Form(395) in the list.
**Add**: Create a new form for this patient. All Sheets with a type of PatientForm or MedicalHistory will list to select from. Consent forms show if the option is checked above.

Note: If no custom PatientForm sheets have been created, the internal Registration Form, Financial Agreement, HIPAA, and Consent forms list by default. When at least one custom sheet PatientForm exists, internal patient form sheet types will no longer list. To get them to show, create a custom copy of each. If no custom MedicalHistory sheets have been created, the internal Medical History Simple will list by default. When at least one custom MedicalHistory exists, only custom medical histories will list.

**To Kiosk**: Highlight one or more forms, then click To Kiosk to put the form in the Kiosk queue. All forms waiting to go to the kiosk will have a number indicating their order in the Kiosk column of the Patient Form window. To change the order, double click on the form, then change the value in the Show Order in Kiosk field.

**Kiosk** (at the bottom of the main window, not this one): Launch the Kiosk(1443) on this computer to allow patient to fill out forms. Alternatively, you can control a dedicated Kiosk from the Kiosk Manager(1444).

**Copy**: Create a new copy of an existing form (useful when updating information).

**Import**: Import completed form data into the database. See Import Patient Forms and Medical Histories(1692).

**Medical History Update**
To have a patient review a previous medical history and make changes, highlight the most recent medical history and click Copy to open it. The copy will not have a signature, and it will have today's date. Print it, or send it to the Kiosk so the patient can make any changes and sign it. Changes will be saved in the new form; they will not overwrite the original. Then import the new form, or enter the changed data.
Import Patient Forms and Medical Histories

When a patient fills out a registration form or a medical history form, the data can be imported into the Open Dental database.

In Patient Forms (1690), click Import.

![Import Patient Form Window](image)

- **FieldName**: The name of the field in the database and on the form.
- **CurrentValue**: Shows a value if information already exists in Open Dental for this field.
- **Entered Value**: What the patient entered on the form. If a value is in red bold text, it cannot be imported.
- **Import Value**: What value, if any, Open Dental has determined should be imported. To change a value, double click on the cell.
- **Do Import**: If an X appears, this field is marked for import. Single click on a cell to toggle the X on/off. When marked for import, the entire row will be grey.

This works for forms filled out via the Kiosk Manager (1444), Web Forms, or eClipboard. The import process differs slightly depending on the sheet type.

**Import a Patient Form (e.g. registration form)**

This window is a review of information on the completed form. Always verify any data with the patient and make sure the correct rows are flagged before you import.

- **FieldName**: The name of the field in the database and on the form.
- **CurrentValue**: Shows a value if information already exists in Open Dental for this field.
- **Entered Value**: What the patient entered on the form. If a value is in red bold text, it cannot be imported.
- **Import Value**: What value, if any, Open Dental has determined should be imported. To change a value, double click on the cell.
- **Do Import**: If an X appears, this field is marked for import. Single click on a cell to toggle the X on/off. When marked for import, the entire row will be grey.
- **DoubleClick to Pick**: The import information is too complex for Open Dental to automatically translate. Double click in the cell to specify the information to import.

- **Insurance Policies**: Only primary and secondary insurance policies can be imported, and the form must contain the following insurance fields:
  - Relationship
  - Subscriber
  - SubscriberID
  - CarrierName
  - CarrierPhone

- **Subscriber**: You will always have to double click to select and verify. If the subscriber does not exist in Open Dental, you must cancel the import and add them.

- **Insurance Carrier Name and Phone**: These rows will also require double clicking each time you import. However, new carriers can be added directly from the Carriers window, so you do not need to cancel the import. By default, the Carriers window will populate with the name and phone values entered by the patient.

When you are ready, click Import again. A Done message will indicate when the import is complete.

New Insurance Plan: If a new insurance plan was flagged for import, the Insurance Plans window will open, and the search filters will populate with the import values. This lets you verify the plan does not already exist.

- To create a new plan using the import values, click Blank.
- To use a plan that already exists, select it and click OK. The import process will verify that all import values exactly match the existing plan's information. If a value does not exactly match, a message will popup, and you will have the option to use the existing plans value (click Yes), or create a new Blank plan with the import values (click No). Click Cancel to safely exit out of the import process and return to the Import window.

Importing an insurance policy does not increase the order to secondary, tertiary, etc. A primary insurance import will overwrite primary insurance policies, and secondary insurance import will overwrite secondary insurance policies. For example, a patient has BCBS for primary insurance and they want to add a new Met Life policy as secondary. The new Met Life information must be entered into the secondary insurance fields on the form in order to be imported into the secondary insurance fields in Open Dental. If entered in the primary insurance fields, the import will overwrite the primary insurance instead (BCBS).

**Import a Medical History**
1. Select the patient, then click Forms in the main Toolbar.
2. Select the completed medical history form, then click Import.
Medical history import values are represented by three states: yes, no and unknown. Empty columns represent unknown, or items which the patient left blank.

3. To change import status, double click in the Import Value cell. If a patient enters new medications, you will always have to double click to select a value from the Medications List. By default, the medication entered by the patient will show in the Search box. Watch for misspellings, as the search will look for an exact match. Select the correct medication and it will appear in the FieldName column under Medications.

4. When you are ready, click Import again. A Done message will indicate when the import is complete.

Medical history import logic:
- If the Current Value = Y and Import Value = N
  - If imported, item status will be set to inactive. It will not be deleted.
  
  Note: For medication, the end date will be set as the current date. It will not be marked inactive until the following day.

- If Current Value = N and Import Value = Y
  - If imported, the item will be made active.

New items will never import with an inactive status.
Registration Forms
Registration forms (1690) are the paperwork patients complete when they first become patients, such as a new patient registration form, medical history, HIPAA form, financial agreement, etc.

Filling Out Forms
There are several ways a patient can fill out registration forms.

Paper Forms: Patients fill out paper forms in your office. Staff enters data into the Open Dental Database, then scans the original documents into the Images module. The originals can be shredded because no paper chart is needed.

Kiosk: Patients fill out forms (setup as sheets) on a kiosk (Kiosk Manager (1444)). You can then import the data into the database.

Web Forms: Before coming in, patients fill out forms (setup as sheets) online via Web Forms Feature. You retrieve completed forms, then can import the data into the database.

eClipboard: Patients can fill out forms electronically using eClipboard. The office can then import the data into the database.

Paper Form Templates
If using paper forms, you are free to adapt these .doc and .gif files for your own use.
- Patient Information: PatientInfo.doc and PatientInfo.gif

These files have the signatures on one page, so if you are scanning and shredding, you only need to scan the page with the signatures, and can destroy the other entering the information into Open Dental.

To create the image files, we print previewed the .doc on a very large screen, captured the screen (Alt-PrintScreen), then pasted it in Corel PhotoPaint and cropped it. If you view the .gif images in Internet Explorer, they may look very choppy at first. Just single click on the image itself to toggle to full resolution. The image quality is quite good.

Other Options
We do not necessarily endorse these companies.


PT Dental: PT Dental Bridge (1053). Import capability.

YAPI: https://yapiapp.com/integrations/open-dental/

Online Forms: These services offer online forms that can be filled out by patients. The information on the form is then typically emailed or securely retrieved by the office. The receptionist must still type the information into Open Dental. There is no place for patients to sign. Some companies providing this service include:
- http://www.patientdocs.com/
- www.logiforms.com
- http://www.formrouter.com/ (no prices listed, probably too expensive)

Task
In the Main Menu (592), click Tasks.
Tasks can be added to a Task List or sent to a User Inbox.

- When a user is subscribed to a task list, new tasks added to that list will pop up.
- Tasks attached to patients also show in the patient's Chart Module(298), Progress Notes.
- If a task is left open on the screen, it will automatically refresh if an edit is made or a note is added by another user.
- When a user receives a new task, a popup shows with a chime sound. To block popups and chime at a user level, click Manage Blocks in the Tasks Area(536).
- If a task is added when the Open Tasks or Main tab is selected, the task will be added under the Main tab.

Add a General Task 
1. To add the task to a specific task list, highlight the task list first. 
2. In the Tasks area, click Add Task. 
3. Enter the task information. See Task Window(1698). 
4. Click OK to send the task to the specified task list. Everyone subscribed to the task list will be notified of the new task. Or, click Send To, then select an inbox to send the task to.

Add a Task attached to the Currently Selected Patient 
1. In the Main Toolbar(1649), click Tasks. 
2. Select the Task List, then click OK. 
Include sub-task lists: Check this box to also show sub-task lists.
3. Enter the task information. See Task Window (1698).
4. Click OK to send the task to the specified task list. Everyone subscribed to the task list will be notified of the new task.
   Or, click Send To, then select an inbox to send the task to.

**Add a Task and Send Copies to Multiple Task Lists**
1. In the Tasks area, click Add Task.
2. Enter the task information. See Tasks Window.
3. Click Send To.
4. Check the box for Send copies to multiple.
5. Select the task lists and click OK.

**Note:** The task will be copied and sent to multiple lists at once. Each copied task will have its own task number assigned.

**Reply to a Task / Add a Note to a Task**
1. Open the task.
2. Click Add to add a Note.
3. Enter the Note. Click Auto Note to insert Auto Notes(317).
4. Click OK to save.
5. Click OK to leave the task in the current task list. Or, click Send To, then select an inbox to send the task to. Or, click Reply to send the task to the last person who sent it.

**Task Window**

The Task window opens when a task is created or task response is received, or double-click an existing task from a task list.

In the **Main Toolbar**(1649), click the **Task**(1695) dropdown, For user. In the Tasks window, click Add Task.

![Task Window](image)

**New**: The read status of a task. All tasks start out marked New, are prioritized at the top of the task list, and appear in the New For tab. The task list icon in the Tasks window will turn orange to indicate new/unread tasks. To mark a task as read, uncheck New or right-click from the task list and **Mark as Read**. The task will be removed from the New For tab and prioritized by date/time and Task Priority in the task list. Read tasks can be marked as New at anytime. Checking New only marks the task new for the user, not all users subscribed to the task list.

**Done**: Complete and close a task. Check Done to close the task and hide it from the task list. Also right-click from the task list and select **Done**. To close a task attached to a patient, right-click the task in the **Chart Module**(298) progress notes and Set Complete. The task will show as complete in the progress notes. Chart module completed task background and text colors can be changed in Definitions: Prog Note Colors(884).

To view completed tasks, from the Tasks window, click Options, and check Show Finished Tasks. Or double-click a task from a patient's chart and uncheck Done. Editing or sending a completed task to another task list automatically removes the Done status.

**Date/Time Created**: Auto-populates with the date and time the task is created. For security purposes, this cannot be edited.
**Date/Time Task**: Typically the same as Date/Time Created. Click Now to enter the current date/time or manually edit to a specific date/time. This field affects the order of the task in the task list.

**Date/Time Finished**: Auto-populates with the date and time the task was marked done or set complete. Click Now to enter the current date/time (does not mark done).

**Reminder**: Set the task to pop up or appear new in the task list for a specific date and time. See Task Reminder (1701). By default, tasks are set to NoReminder.

**From User**: Name of the user that created the task. To change the user, click [...] and select a new user from the list. If changed, the original user will no longer be able to see edits to the task unless the user is subscribed to the task list the task is sent to.

**Task List**: Auto-populates with the name of the task list the task is currently in or being sent to. To change, click Send To (see below).

**Task Priority**: Assign a priority to the task. Tasks are sorted by the New status, Task Priority, then date and time. Add or edit priority types in Definitions: Task Priorities (891).

**History**: View summary of task changes. Only available if the user has Security Permissions (1118) for TaskEdit.

- **CreateDate**: Original date of the task.
- **Edit Date**: Date the task was change.
- **Editing User**: User who made the change.
- **Changes**: Description of the change.

**Description**: Enter the task description. This text box supports Right Click Text Box (319) options. To change the height of the description box, drag the splitter bar between the Description text box and Notes grid and drag to the desired height.
- Add Wiki (1484) links to a task so users can right-click the task and go directly to the wiki page. To add a link, enter the wiki page title surrounded by double brackets (i.e., [[wiki page title]]).
- Use Quick Paste Notes (1088) to quickly add frequently used notes. Enter the quick note shortcut or right-click and select Insert Quick Note. The quick note must be in a quick note category assigned to tasks to work.
- Add web URLs to a task so users can right-click the task and go directly to the web page. To add a URL, copy and paste into the task description.

**Edit Auto Note**: Click to resume filling out a previously started Auto Note.

**Auto Note**: Insert an Auto Note (317) template to the task description.

**Notes**: Comments and notes added by users. Double-click into a note to make changes. User must have Task Note Edit security permissions.
- **Date Time**: The date and time a user added a note.
- **User**: Name of the user that added a note.
- **Note**: Note text added by the user.

**Add**: Opens the Task Note Edit window to add comments and notes to the task.
Date/Time: Auto-populates with the date and time the note is created.
User: Name of the user adding the note.
Note: Additional task comments or notes. Also support wiki links, quick notes, web URLs, and auto notes.
Delete: Removes entire note from task.
OK: Saves the note.
Cancel: Exits the Task Note Edit window without saving changes.

Reply: Opens the Task Edit Note window to add a note. Click OK to immediately send the task with the reply back to the inbox of the last user that commented.

Send To: Moves the task to the selected task list. Click to open the Select Task List window. Task lists with the same Object Type as the task will show. Type the task list name in the Search field or select from the available task lists then double-click or click OK to move the task.

Copy: Copies the task number, date/time stamps, patient name and appointment date/time (if attached), task description, notes, and associated users to the clipboard.

Object Type: Attach a task to an appointment or patient. Attached patient related tasks to an appointment or patient to quickly access the patient or jump to the appointment.
None: Task is not attached to an appointment or patient and the task cannot be sent to a task list with these object types. Tasks can still be sent to user inboxes. Tasks with object type None cannot be tracked in the New For or Open Tasks tabs.
Patient: Task is attached to a patient and shows in the patient's progress notes and Patient Tasks tab. Patient name will show last name, preferred name (if entered), first name, and patnum.
Appointment: Task is attached to an appointment.

Change: Change attached patient or appointment. Only available if the object type is set to Patient or Appointment. Click Change to open the Select Patient(1649) window and select a patient to attach (only one patient can be attached). When the object type is set to Appointment, Change opens the Select Patient window and when a patient is selected, the Patient Appointments(24) window opens to select the patient's appointment to attach.

Go To: Exits the Task window and changes the currently selected patient to the patient attached to the task. When the object type is Appointment, the active modules changes to Appointments Module(1) and jumps to the date of the appointment in the calendar.

OK: Exits the Task window and saves changes.
Cancel: Exits the Task window without saving changes.
Delete: Deletes the task and task notes. An audit trail entry will be created but the task cannot be retrieved once deleted.
Task Reminder

When using Tasks(1695), reminders can be used to remind staff of tasks that need to be done daily, weekly, monthly, or yearly.

1. Enable tasks and set up user inboxes and task lists. See Tasks Preferences(1192).
2. Create a task reminder, setting type, date/time and repeat interval.
3. When the reminder is due, it will pop up and appear in the task list. Mark the reminder done to make it disappear until its next due date.
4. When you no longer want the reminder to appear, change the Reminder Type to NoReminder.

Note: All users subscribed to the task list will receive the reminder until it is marked done.

How task reminders work

- The time a task reminder appears will be based on the time it is created (Date/Time Entry). For example, a time entry of 3:45 pm will cause a daily reminder to appear at 3:45 pm each day.
- Task Priority determines color. Light orange is the default color for Reminder priority and task reminders. Edit defaults in Definitions: Task Priorities(891).
- Reminder tasks will be turned off if office is using Legacy tasks. See Task Preferences.
- Reminders are tracked in the Audit Trail(1424).

Create a task reminder

Examples:
- Daily type, every 1 day, will cause a reminder to appear every day.
- Weekly type, every 2 weeks, F, will cause a reminder to appear every 2 weeks on Friday.
- Yearly type, every 1 year, will cause a reminder to appear every year on the date.

1. In the Tasks area, select the task list the reminder will show in, then click the Add Task dropdown, Reminder. Or, click the Reminders tab then Add Task.
2. **Date/Time Task**: Enter the date/time you want the reminder to first appear. The default is today at the current time.

3. **Reminder Type**: Select the type of reminder:
   - NoReminder: Selected by default for normal tasks. This task is not a reminder.
   - Once: Selected by default when adding a reminder task using the Add Task, Reminder dropdown or when the Reminders tab is selected. Use the calendar dropdown and time picker to choose a date and time. The reminder will appear once on the selected date and time.
   - Daily: This reminder appears once per day.
   - Weekly: This reminder type appears weekly on a designated day or days.
   - Monthly: This reminder type appears once per month.
   - Yearly: This reminder type appears once per year.

4. **Reminder Every** __: Enter the repeat frequency. For example, Every3days, Every2weeks, Every1year.

5. **Reminder Days**: Only shows for weekly repeat interval. Select the day of the week the reminder should appear:
   - M = Monday
   - T = Tuesday
   - W = Wednesday
   - R = Thursday
   - F = Friday
   - S = Saturday
   - U = Sunday.

6. **Task Priority**: Select the task priority to organize reminders by importance. The default is Reminder with a color of light orange. Add options in Definitions, Task Priorities.

7. **Description**: Enter the text of the reminder.

8. If the Task List is already selected, click OK. Or, click Send To, select the task list to send the reminder to and click OK.

### Complete or remove task reminders
To mark a task reminder as complete and remove it temporarily from your list until the next due date, mark it Done. This will create a new reminder task for the next interval date.

To stop a task reminder from repeating, set the repeat interval to Once or NoReminder.

To permanently remove a task reminder from a task list, delete it.

**Note**: To view task reminders that have been marked Done, in the Tasks area, click Options, Show Finished Tasks.

### Task reminder history
A history of task reminders shows under the Reminders tab, grouped by task list.
The list includes:
- New/viewed task reminders.
- Task reminders due in the future.
- If Show Finished Tasks is selected, task reminders marked Done also show.

To view a history of all actions taken on a task reminder, open the task reminder and click History.

- Create Date: The original date of the task.
- Edit Date: The date the change was made.
- Editing User: The user who made the change.
- Changes: A description of the change.

Repeating Task Lists (Legacy)
Legacy repeating tasks are an older method of setting task reminders. Use Task Reminders (1701) as an updated alternative to repeating task lists.
Repeating task lists are automatically generated checklists that can be used to mark off tasks you do repeatedly. For example:

- Daily tasks in the sterilization room.
- Weekly tasks for stocking supplies.
- Monthly tasks for equipment maintenance.

As you complete tasks, mark them Done under the By Date, By Week, or By Month tab to clear them from the list. They will reappear each day, week, or month depending on the Date Type setting (Day, Week, Month). Lists and tasks can be nested inside other repeating task lists, much the folder/file concept.

If using repeating tasks:

- Reminders are not sent to you.
- You cannot go to one place and see everything you need to do today.
- The list does not specify who needs to do the task.
- A supervisor must go to each list to see what is missed.
- You cannot subscribe to repeating task lists.

Because you no longer have a list hanging on a wall and there is no reminder, staff must remember to perform the task, go into the repeating task list and mark the task done.

**Set Up a Repeating Task List**
Click Setup, Tasks, then check Show legacy repeating tasks to enable. See Tasks Preferences(1192).

1. In the Tasks Area, click the Repeating (setup) tab.
2. Click Add Task List.
3. Enter the task list name as the Description (e.g. Equipment Maintenance).
4. Select a Date Type for the task list. This determines which Date tab it will appear under. Day: For daily tasks (By Date tab).

   Week: For tasks done once a week (By Week tab).

   Month: For tasks done once a month (By Month tab).

To create nested lists, highlight an existing repeating list first, then click Add Task List. Nested lists inherit the date type of parent lists.

Note: Task lists are sorted alphabetically. Numbering them may help with organization.
Add Repeating Tasks to a Repeating Task List

1. In the Tasks Area, click the Repeating (setup) tab.
2. Highlight the task list.
3. Click Add Task.
4. Enter the task description (e.g. Confirm patients).
5. Click OK.

The task will list under the tab that matches the date type of the task list.

Use Repeating Tasks
There are three date tabs: By Date, By Week, By Month. Within these tabs are the task lists and tasks that fit the criteria (date type of day, week, or month). As you complete tasks, mark them done and add notes. When marked done, they will disappear from the list. The next period (next day, next week, or next month), the task will show in the list again.

When you click a date tab, in addition to task lists and tasks, an interactive calendar will show.

When you click a date tab, in addition to task lists and tasks, an interactive calendar will show.

Task List and Inbox
In the Tasks area, in the Main tab, click Add Task List.

- Alternatively, open a task list and click Add Task List to create a sub-task list within a main task list.
- To edit an existing task list, right-click the list and select Edit Properties.

Task Lists are a way to organize tasks. A task list can have nested task lists or tasks within it, much like the folder/file concept. A user's inbox is also considered a task list. The Task List Create security permission is required to add a task list.

**Description:** Enter the task list name.

**Date:** Leave blank. Only used with Repeating Task Lists (Legacy) (1703)

**Date Type:** Set to none. Only used with Repeating Task Lists (Legacy).
**Is From Repeating:** Leave unchecked unless using Repeating Task Lists (Legacy).

**Object Type:** Select whether to attach patients or appointments to tasks in this list.
- **Patient:** Select when setting up an inbox, or if you want this task list to be available in the main toolbar when you click To Task List.
- **Appointment:** Select when you want this task list to be available when you click To Task List in the Edit Appointment window.

**Global Filter Override:** Only available when Global Filter for Task Lists is enabled.
- **Default:** This task list will automatically use the filtering option selected in Tasks Preferences.
- **None:** This task list will not automatically filter. This overrides the selection set in Task Preferences.
- **Clinic:** This task list will automatically filter by the selected clinic. This overrides the selection set in Task Preferences.
- **Region:** This task list will automatically filter by region. This overrides the selection set in Task Preferences.

**Set up a User Inbox**
A User Inbox is a task list that contains tasks sent directly to a specific user when you click Send To or Reply.

For each inbox, create a task list for the user and select Patient as the task list's Object Type.

In the Main Menu, click Setup, Tasks, Inbox Setup.

Current users appear on the left. All existing task lists appear on the right. To add or edit users, see User Edit.
To set an inbox, highlight the user on the left, then the associated task list on the right, and click **Set.** Repeat for each user you want to create an inbox for.

Have each user log in and subscribe to their inbox.

**Task Search**

You can search for a task using multiple criteria.

In the **Tasks** area, click **Search.**

Enter the search parameters on the right then click **Refresh.** Multiple criteria can be entered. Click **New Task** to create a new task from the Task Search window.

Double-click a task to open it.

Below is a description of each parameter:

- **User:** Search for tasks that have this user in its description or notes. The default selection is All. Me is a quick method of selecting the logged-in user.
- **Task List:** Search in task lists (description) that have matching characters.
- **Task Num:** Search by task number (headquarters only).
- **Description:** Search task description and notes for matching characters.
- **PatNum:** Search for tasks associated with a patient number (for tasks that have a Patient type only).
- **Priority:** Search by task priority.
- **Date Created (From / To):** Search for tasks that have a Date/Time Entry between the date range.
Click the calendar icon to select the to and from dates.

Click Clear to clear all dates.

- **Date Completed (From / To):** Search for tasks that have a Date/Time Finished between the date range.

Click the calendar icon to select the to and from dates.

Click Clear to clear all dates.

**Include Task Notes:** When checked, applies filters to task notes when searching.

**Include Completed:** When checked, includes completed tasks in search.

**Limit Results (50):** When checked, search results are restricted to 50 tasks. When unchecked, there will be no limit.

**Run on Report Server:** Only visible for offices using a report server ([Report Setup: Report Server](1094)). Check to run the task search query on the report server to avoid slowness.

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**Labels**

In the [Main Toolbar](1649), click Label.

Labels can be printed one at a time or by sheet. They can be customized in [Sheets](1123).

Click the Label dropdown to select a different label option.

- If no custom labels have been created, all internal label sheet options will show.
- If custom labels have been created, only the custom labels will show.

This table has been ommitted.

**Individual Labels**

Individual labels are useful for single address labels for a patient, insurance carrier, referrals, or for labeling patient records.

To print labels one at a time use a special label printer. A dedicated label printer costs about $150-$200. Since it uses thermal printing technology, it requires special labels made specifically for thermal printers. It plugs into the USB port and requires some installation. Once you setup your label printer as a Windows printer, go to the Printer Setup on the workstation where you will be printing labels. Set labels to print on your new printer with no prompt.

There are several places where single labels can be printed. Labels do not display on the screen before printing and are not saved in the database.

**Patient Labels:** The label printed is determined by the label selected in Sheet Setup for Label assigned to patient button. By default, it is the internal Label Patient Mail.

**Insurance Carrier Label**

- In the main toolbar, click the Label dropdown and select the carrier.
- On the [Insurance Plan](81), click Label.
- On the [Claim](208) click Label
- On the [Insurance Claims](489) window, highlight the claims, then click Labels. Single labels will print for those carriers.

**Labels for Referrals:** In the toolbar, click the Labels dropdown, then click the Referral name.

**Single Appointment Labels:** In the [Appointments Module](1), right click on an appointment and click Print Label.

**Sheets of Labels**
Print sheets of labels on a laser or inkjet printer. This method is useful when printing large quantities of labels for Recalls, birthday cards, etc., although many offices prefer laser postcards instead. The disadvantage to this method is leftover labels on the sheet that are hard to run through the printer again. The Recall List(27) has built-in functionality for printing sheets of labels.

There is also a Laser Labels(1277) feature which can print labels for patients, insurance companies, and birthdays.

If you need sheets of labels for any other purpose, you have to create a report, export to a text file, and then merge into your own Word template.


**Popups**

In the Main Toolbar(1649), click Popups.

Popups are automatic messages that are triggered when you open a patient's record and look like this:

Click OK to acknowledge a popup.

- Note: Once acknowledged, a popup will not show again on the workstation until at least 10 minutes have passed. See Add or Edit Popups below to determine the last time a popup was viewed on the workstation.
- Changes to popups are tracked in the popup audit trail, and any deletions are permanently archived.
Add or Edit Popups

With a Patient Selected, in the Main Menu, click Popups. Active and disabled popups are listed. To view popups that have been deleted, check the Show Deleted box. Last Viewed indicates the last time the popup was viewed on this workstation.

Double click an existing popup to edit, or click Add.

Level dropdown, Popup Message text box, and Delete button will be disabled if the popup belongs to another user and the current user does not have the Edit Popup security permission. Users can still edit and delete their own popups without the permission.

Level: Select when this popup will be triggered. Popups are only triggered when you switch to a patient record; moving between modules will not trigger popups.
- Patient: Triggered when you switch to this patient.
- Family: Triggered when you switch to any member of the patient’s family.
- Superfamily: Triggered when you switch to any member of the patient’s super family. The patient must be part of a super family for this option to be available. See Super Family.

Permanently Disabled: Check to disable the popup so that it is no longer triggered when you switch patients. It will still list in the Popup list.

Popup Message: Enter the popup message.

Delete: Remove the popup from the Popup list. It will no longer be triggered, but can still be viewed when you select Show Deleted on the Popups for Family window.

Audit Trail: Click to view a log of any changes made to the message in this popup. User, date and time are tracked. Double click on a popup to open the Edit Popup window. Changing a level or disabling a popup is not tracked in this audit trail.
<table>
<thead>
<tr>
<th>Create Date</th>
<th>Edit Date</th>
<th>Level</th>
<th>Disabled</th>
<th>Popup Message</th>
</tr>
</thead>
<tbody>
<tr>
<td>11/01/2013 11:56:41 AM</td>
<td></td>
<td>Family</td>
<td></td>
<td>Verify address and phone number</td>
</tr>
<tr>
<td>11/01/2013 11:56:41 AM</td>
<td>11/01/2013 12:08:42 PM</td>
<td>Family</td>
<td></td>
<td>Verify cell phone number is accurate</td>
</tr>
<tr>
<td>Topic</td>
<td>Page</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>--------------------------------------------------------------</td>
<td>------</td>
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<td></td>
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<td>&quot;Security Admin&quot; Permission</td>
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<td></td>
<td></td>
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<tr>
<td>&quot;Setup&quot; Permission</td>
<td>1118</td>
<td></td>
<td></td>
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