S O A P

S: SUBJECTIVE: This section is for any information the patient tells us (assistant or prior to the start of the procedure. Including MHU.

O: OBJECTIVE: This section is for any information we (assistant or Dentist) see before the start of the procedure.

A: ASSESSMENT: This section is to state the procedure we are performing today prior to the start of the procedure. This may be what is scheduled for the treatment plan or it may have been an Emergency appointment.

P: PROCEDURE: This section is what we actually did for the patient.

RX: Any OTC (over the counter) or prescribed medicine written exactly as instructed. If there are none, don’t include.

N: NOTE: Any extra information that would be helpful or we forgot to put in the above sections. If there are none, don’t include.

NV:NEXT VISIT: The next visit to include what needs to be scheduled and Recommended date (time frame). i.e. within one week. (Dr. initials).

LAB: What lab you sent the crown/bridge/or prosthetics to.

SHADE: Shade you or the patient picked for the restoration.

INS. EXP: You must write a reason why the crown/bridge or prosthetic was done. If existing crown/bridge or prosthetic present, how old is that Restoration.

Build-up Explanation: Build-up for increased retention.