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Awareness and Practice of Orthodontic Record-Keeping and Radiographic Documentation among Iraqi Orthodontists: A Cross-Sectional Study

Lubna Makki Hussein
B.D.S., MSc. Orthodontics
Department of Orthodontics, College of Dentistry, University of Kufa, Kufa, Iraq

Ayat M. Hussein
B.D.S., MSc. Orthodontics
Department of Orthodontics, College of Dentistry, Dijlah University, Baghdad, Iraq

Shahad Dhurgham Ali
B.D.S., MSc. Oral and Maxillofacial Radiology
Department of Oral Diagnosis, College of Dentistry, University of Kufa, Kufa, Iraq

Corresponding Author
Lubna Makki Hussein
Department of Orthodontics, College of Dentistry, University of Kufa
Kufa, Iraq

Abstract

Background: Accurate and comprehensive orthodontic records are essential for precise diagnosis, effective treatment planning, treatment monitoring, medico-legal protection, and long-term patient care. Recent technological advancements have improved the methods of recording, storing, and managing orthodontic records; however, the extent to which these practices are consistently implemented in routine clinical settings remains uncertain.

Aim of the Study: to evaluate the level of awareness and clinical practices related to orthodontic record-keeping among Iraqi orthodontists and to investigate age-related differences in awareness and record-management practices.

Materials and Methods: A cross-sectional online survey was conducted among Iraqi orthodontists from January to March 2026 using a structured questionnaire. The questionnaire assessed demographic characteristics, awareness of essential orthodontic

records, and practices related to record storage, retention, and disposal. A total of 71 valid responses were included in the statistical analysis. Data were analyzed using descriptive statistics, Pearson's Chi-square test, or Fisher's Exact test when appropriate, with statistical significance set at $p < 0.05$.

Results: Most participants demonstrated high awareness regarding the importance of documenting patient details, medical history, radiographs, and pre- and post-treatment photographs. Orthopantomograms were routinely used, whereas lateral cephalometric radiographs were obtained selectively according to clinical requirements. Conventional handwritten record systems remained the predominant method of documentation, while digital dental models were infrequently used. Significant associations were observed between age groups and specific aspects of record documentation and organization, whereas record retention and disposal practices showed no significant age-related differences.

Conclusion: Iraqi orthodontists demonstrated adequate awareness regarding orthodontic record-keeping; however, a noticeable gap persists between awareness and consistent clinical implementation. The development of standardized protocols, wider adoption of digital record systems, and continuous professional education may improve the quality, efficiency, and legal reliability of orthodontic record-keeping practices.

Keywords: orthodontics; dental records; legal awareness; record keeping; Iraqi orthodontists.

1. Introduction

Accurate and comprehensive dental records are fundamental components of high-quality patient care and are considered essential in orthodontic practice. Orthodontic records provide the basis for precise diagnosis, appropriate treatment planning, monitoring of treatment progress, and evaluation of treatment outcomes (1-6). In addition to their clinical importance, orthodontic records serve as valuable tools for communication between the orthodontist and the patient and contribute substantially to medico-legal protection and professional accountability. Therefore, maintaining complete and updated records throughout treatment is considered a professional and ethical responsibility.

Orthodontic documentation commonly includes patient demographic information, medical and dental histories, clinical examination findings, radiographs, photographs, study models, and detailed treatment notes (6). Continuous updating of these records is important to monitor changes in the hard and soft tissues during treatment and to ensure proper documentation of all clinical procedures and communications. Previous studies have emphasized that accurate orthodontic documentation plays a major role in improving treatment quality, facilitating professional self-assessment, supporting scientific research, and enhancing patient education (1-3).

Recent technological advancements have substantially influenced orthodontic practice, particularly in the field of record management and storage. The introduction of digital technologies, including digital photography, virtual study models, cone-beam computed tomography, and computerized record systems, has improved the efficiency, accuracy, accessibility, and long-term preservation of orthodontic records (2,7-9). Orthodontic treatment is usually prolonged and involves continuous follow-up, making accurate documentation essential for minimizing medico-legal risks and protecting both patients and clinicians (7,10-12).

Furthermore, digital systems provide advantages in data retrieval, communication, storage capacity, and reproduction of diagnostic records compared with conventional handwritten methods. Consequently, the adoption of digital technologies has become increasingly important for improving the quality and efficiency of orthodontic care (2,13,14). The American Dental Association (ADA) has established guidelines emphasizing the importance of maintaining detailed, accurate, and confidential patient records, including medical histories, clinical findings, treatment plans, radiographs, and all treatment-related communications (11). Compliance with these standards is considered necessary to maintain professional practice and ensure legal and ethical responsibilities.

Despite the increasing importance of standardized orthodontic documentation and the growing adoption of digital technologies worldwide, limited information is available regarding the actual record-keeping practices and legal awareness among Iraqi orthodontists. Therefore, the present study aimed to evaluate the level of awareness and clinical practices related to orthodontic record-keeping among Iraqi orthodontists and to investigate possible differences according to age groups.

2. Material and Methods

Study Design and Setting

A cross-sectional survey was conducted among practicing Iraqi orthodontists from different governorates across Iraq to evaluate awareness and clinical practices related to orthodontic record-keeping. The study was carried out through

the Department of Orthodontics, College of Dentistry, University of Baghdad, Iraq, and data were collected from January to March 2026.

Study Population and Sampling

A purposive sampling method was adopted, as the study specifically targeted practicing Iraqi orthodontists. A total of 100 orthodontists participated in the study through an online questionnaire. Seventy-one complete responses were received and included in the final analysis, yielding a response rate of 71%.

Questionnaire Design and Validation

A structured questionnaire was prepared based on evidence and recommendations derived from previously published studies and relevant guidelines on orthodontic record-keeping. The questionnaire consisted of three main sections:

1. Demographic characteristics of the participants
2. Awareness and documentation of orthodontic patient records (history and clinical examination).
3. Practices related to storage, maintenance, retention, and disposal of orthodontic records.

The questionnaire was developed based on previously published studies and relevant guidelines. Content validity was assessed by a panel of five professional orthodontists who evaluated the questionnaire for relevance, clarity, and comprehensiveness. The questionnaire demonstrated satisfactory content validity, with I-CVI values ranging from 0.80 to 1.00 and an S-CVI/Ave of 0.91. Subsequently, a pilot study was conducted on 10 orthodontists to assess the clarity, comprehensibility, and feasibility of the questionnaire prior to its final distribution. The interpretation of content validity indices was performed according to the recommendations of Polit et al. (15).

Data Collection Procedure

The questionnaire was distributed electronically using Google Forms. Participants were allowed to submit only one response. Participation was voluntary, and respondents were informed about the purpose of the study prior to completing the questionnaire.

Ethical Considerations

Prior to the commencement of the study, ethical approval was obtained from the institutional ethics and research committee of the College of Dentistry, University of Baghdad.

Statistical Analysis

After data collection, all responses were recorded in Microsoft Excel and then transferred to SPSS software for statistical analysis. Descriptive statistics were expressed as frequencies and percentages. Associations between categorical variables were assessed using Pearson's Chi-square test or Fisher's Exact test when appropriate. Fisher's Exact test was substituted whenever the expected cell frequencies were less than 5. Statistical significance was set at $p < 0.05$.

3. Results

A total of 71 orthodontists completed the questionnaire and were included in the final analysis. All respondents (100%) reported that they document and maintain orthodontic records in their clinical practice. Table 1 shows demographic and professional characteristics of the participants.

Table 2 shows that most respondents (93%) consistently documented basic patient details, while informed consent was always obtained by 30%, sometimes by 49%, and never by 21%. Medical history was always recorded by 80%, and oral health status was considered important by 92%. Orthodontic charting was always performed by 65%, malocclusion classification by 87%, and overjet/overbite by 83%, while crowding assessment was considered important by 59% and sometimes necessary by 41%. Lateral cephalograms were always used by 18% and sometimes by 77%, whereas orthopantomograms were always used by 93%. Intra-oral periapical radiographs were always used by 3%, sometimes by 83%, and not used by 14%. Pre-treatment and post-treatment photographs were always taken by 93% and 97%, respectively, while intra-treatment photographs were always taken by 31% and sometimes by 68%. Pre-treatment models were always required by 21%, sometimes by 59%, and never by 20%, while 68% reported no use of models during treatment; post-treatment models were always used by 39% and never by 31%. Digital model storage was rarely used (1% always, 70% never), and physical storage was inconsistent (27% always, 39% never).

Table 3 shows that most participants followed a regular system for the storage, maintenance, and retention of orthodontic records (93%), acknowledged legal obligations (77%), relied mainly on handwritten records (68%), organized records by date (44%), and retained records for more than one year (92%), including non-

reporting and medico-legal cases, with varied disposal methods. One participant did not respond to Question 6; therefore, analyses related to record retention for non-reporting/inactive patients were based on 70 responses.

Table 1: Demographic and professional characteristics of the participants.

Part 1: General information	N	%
Male	29	41
Female	42	59
MSc.	56	79
Ph.D.	15	21
Orthodontic practice /Yes	71	100
Orthodontic practice /No	0	0
Experience / Less than 2 years	17	24
Experience / More than 2 years	54	76

Table 2: Documentation of orthodontic patient records.

Part 2: Patient records (History and Examination)		**Always**	**Sometimes**	**never**	**Total**
Patient Details	N	66	5	0	71
	%	93	7	0	100
Informed Consent	N	21	35	15	71
	%	30	49	21	100
Medical History	N	57	14	0	71
	%	80	20	0	100
Oral Health Status	N	65	6	0	71
	%	92	8	0	100
Orthodontic Charting a.skeletal pattern	N	46	20	5	71
	%	65	28	7	100
Orthodontic Charting b.malocclusion classification	N	62	9	0	71

	%	87	13	0	100
Orthodontic Charting c.Over-jet & Overbite	N	59	12	0	71
	%	83	17	0	100
Orthodontic Charting d.Degree of crowding	N	42	29	0	71
	%	59	41	0	100
Radiographs a.Lateral Cephalogram	N	13	55	3	71
	%	18	77	4	100
Radiographs b.OPG	N	66	5	0	71
	%	93	7	0	100
Radiographs c.Intra oral perapical radiograph	N	2	59	10	71
	%	3	83	14	100
Photographs a. Before treatment	N	66	4	1	71
	%	93	6	1	100
Photographs b. During treatment	N	22	48	1	71
	%	31	68	1	100
Photographs c. After treatment	N	69	1	1	71
	%	97	1	1	100
Dental model a. Before treatment	N	15	42	14	71
	%	21	59	20	100
Dental model b. During treatment	N	0	23	48	71
	%	0	32	68	100
Dental model c. After treatment	N	28	21	22	71
	%	39	30	31	100
Dental models type a.Digital	N	1	20	50	71
	%	1	28	70	100
Dental models type b.Physical	N	19	24	28	71
	%	27	34	39	100

Table 3: Practices related to storage, retention, and maintenance of orthodontic patient records.

Part 3: Practice of Storage and Maintenance of Patient Records		Response				Total
		A	B	C	D	
Q1	N	66	1	4		71
	%	93	1	6		100
Q2	N	55	4	12		71
	%	77	6	17		100
Q3	N	48	12	11		71
	%	68	17	15		100
Q4	N	31	21	19		71
	%	44	30	27		100
Q5	N	2	4	65		71
	%	3	6	92		100
Q6	N	8	14	48		70
	%	11	20	69		100
Q7	N	2	4	65		71
	%	3	6	92		100
Q8	N	7	6	3	55	71
	%	10	8	4	77	100

Note: Detailed descriptions of Q1–Q8 and their corresponding response options are presented in the Appendix.

Table 4 showed the relation between age groups and awareness of orthodontic record keeping using Pearson's Chi-square test or Fisher's Exact test when appropriate. The participants were divided into three age groups: ≤35 years (n=36), 36–45 years (n=27), and >45 years (n=8). Data are presented as numbers and percentages of respondents who answered always, which represent adequate awareness. Statistical significance was set at $p < 0.05$. Statistically significant associations were found between age groups and orthodontic charting (degree of crowding), p=0.008; radiographs (lateral cephalogram), p=0.048; and dental models (physical storage), p=0.045, while other awareness items did not differ significantly across age groups (p>0.05).

Table 4: Association between age groups and awareness of orthodontic record keeping.

Awareness items	Age groups			p-value
	≤35 yrs n (%)	36–45 yrs n (%)	>45 yrs n (%)	
Patient details	32/36 (88.9%)	26/27 (96.3%)	8/8 (100.0%)	0.372
Informed consent	12/36 (33.3%)	7/27 (25.9%)	2/8 (25.0%)	0.780
Medical history	28/36 (77.8%)	24/27 (88.9%)	5/8 (62.5%)	0.223
Oral health status	32/36 (88.9%)	25/27 (92.6%)	8/8 (100.0%)	0.575
Orthodontic charting – skeletal pattern	21/36 (58.3%)	19/27 (70.4%)	6/8 (75.0%)	0.499
Orthodontic charting – malocclusion classification	31/36 (86.1%)	25/27 (92.6%)	6/8 (75.0%)	0.402
Orthodontic charting – overjet & overbite	27/36 (75.0%)	25/27 (92.6%)	7/8 (87.5%)	0.172
Orthodontic charting – degree of crowding	15/36 (41.7%)	20/27 (74.1%)	7/8 (87.5%)	0.008
Radiographs – lateral cephalogram	5/36 (13.9%)	4/27 (14.8%)	4/8 (50.0%)	0.048
Radiographs – OPG	35/36 (97.2%)	23/27 (85.2%)	8/8 (100.0%)	0.129
Radiographs – intraoral periapical radiograph	1/36 (2.8%)	1/27 (3.7%)	0/8 (0.0%)	0.857
Photographs – before treatment	36/36 (100.0%)	23/27 (85.2%)	7/8 (87.5%)	0.061
Photographs – during treatment	13/36 (36.1%)	8/27 (29.6%)	1/8 (12.5%)	0.418
Photographs – after treatment	36/36 (100.0%)	25/27 (92.6%)	8/8 (100.0%)	0.187
Dental model – before treatment	5/36 (13.9%)	7/27 (25.9%)	3/8 (37.5%)	0.248
Dental model – during treatment	0/36 (0.0%)	0/27 (0.0%)	0/8 (0.0%)	1.000
Dental model – after treatment	13/36 (36.1%)	11/27 (40.7%)	4/8 (50.0%)	0.756

Digital Dental models	1/36 (2.8%)	0/27 (0.0%)	0/8 (0.0%)	0.611
Physical dental models	5/36 (13.9%)	11/27 (40.7%)	3/8 (37.5%)	0.045

Table 5 presents the relationship between different age groups and orthodontic record management practices, as assessed using Pearson's Chi-square test or Fisher's Exact test when appropriate. A statistically significant association was observed between participants' age and their practice of maintaining orthodontic patient records ($p = 0.047$), as well as the system used for organizing records ($p = 0.031$). In contrast, no significant association was observed between age groups and other practices.

Table 5: Association between age groups and record management practices in orthodontics.

Practice item	Response Category	Age groups			p-value
		≤35 yrs n (%)	36–45 yrs n (%)	>45 yrs n (%)	
Q1. Follow a regular system for the storage, maintenance, and retention of orthodontic records	No	0/36 (0.0%)	1/27 (3.7%)	0/8 (0.0%)	0.047
	Sometimes	0/36 (0.0%)	2/27 (7.4%)	2/8 (25.0%)	0.047
	Yes	36/36 (100.0%)	24/27 (88.9%)	6/8 (75.0%)	0.047
Q2. Awareness of legal obligation	Don't know	5/36 (13.9%)	7/27 (25.9%)	0/8 (0.0%)	0.326
	No	3/36 (8.3%)	1/27 (3.7%)	0/8 (0.0%)	0.326
	Yes	28/36 (77.8%)	19/27 (70.4%)	8/8 (100.0%)	0.326
Q3. Method of record maintenance	Handwritten	25/36 (69.4%)	20/27 (74.1%)	3/8 (37.5%)	0.144
	Printed forms	10/36 (27.8%)	11/27 (40.7%)	2/8 (25.0%)	0.494
	Digital records	12/36 (33.3%)	12/27 (44.4%)	6/8 (75.0%)	0.093
Q4. System used for organizing records	By date	21/36 (58.3%)	7/27 (25.9%)	3/8 (37.5%)	0.031

	Alphabetical order	5/36 (13.9%)	12/27 (44.4%)	4/8 (50.0%)	0.031
	Customized serial number to the file	10/36 (27.8%)	8/27 (29.6%)	1/8 (12.5%)	0.031

Table 6 illustrates the association between age categories and record retention practices in orthodontics using Pearson's Chi-square test or Fisher's Exact test when appropriate. There was no statistically significant relation between age group and the duration of retaining records for active patients. ($p = 0.845$), inactive patients ($p = 0.494$), and medico-legal records ($p = 0.922$).

Table 6: Association between age groups and record retention practices in orthodontics.

Practice item	Response category	≤35 yrs n (%)	36–45 yrs n (%)	>45 yrs n (%)	p-value
Q5. Management of Record Retention for Different Patient Statuses (Active, Ongoing, Completed)	a. Records are not retained	1/36 (2.8%)	1/26 (3.8%)	0/8 (0.0%)	0.903
	b. Retention period < 1 year	2/36 (5.6%)	2/26 (7.7%)	0/8 (0.0%)	0.903
	c. Retention period > 1 year	33/36 (91.7%)	23/26 (88.5%)	8/8 (100.0%)	0.903
Q6. Retention of records for non-reporting/inactive patients	a. Records are not retained	4/35 (11.4%)	2/27 (7.4%)	2/8 (25.0%)	0.360
	b. Retention period < 1 year	6/35 (17.1%)	5/27 (18.5%)	3/8 (37.5%)	0.360
	c. Retention period > 1 year	25/35 (71.4%)	20/27 (74.1%)	3/8 (37.5%)	0.360
Q7. Retention of records for medico-legal cases	a. Don't preserve	1/35 (2.9%)	1/27 (3.7%)	0/8 (0.0%)	0.914
	b. Less than 1 year	2/35 (5.7%)	2/27 (7.4%)	0/8 (0.0%)	0.914
	c. More than 1 year	32/35 (91.4%)	24/27 (88.9%)	8/8 (100.0%)	0.914

As illustrated in Table 7, the relationship between age groups and record disposal practices in orthodontics was assessed using Pearson's Chi-square test or Fisher's Exact test when appropriate. The analysis revealed no statistically significant association between age group and the disposal method of orthodontic records following the retention period ($p = 0.113$).

Table 7: Association between age groups and record disposal practices in orthodontics.

Practice item	Response category	≤35 yrs n (%)	36–45 yrs n (%)	>45 yrs n (%)	p-value
Q8. Disposal of records after retention period	a. Give them back to the patients	3/35 (8.6%)	2/26 (7.7%)	2/8 (25.0%)	0.113
	b. Incineration/Shredding	1/35 (2.9%)	5/26 (19.2%)	0/8 (0.0%)	0.113
	c. Disposal of records through external agencies.	2/35 (5.7%)	0/26 (0.0%)	1/8 (12.5%)	0.113
	d. None of the above	29/35 (82.9%)	19/26 (73.1%)	5/8 (62.5%)	0.113

4. Discussion

The present study evaluated the level of awareness and clinical practices related to orthodontic record-keeping among Iraqi orthodontists.The findings demonstrated a generally high level of awareness regarding the importance of maintaining essential orthodontic records, including patient details, medical history, radiographs, photographs, and orthodontic charting. These findings are consistent with previous studies that emphasized the important role of orthodontic records in diagnosis, treatment planning, monitoring treatment progress, medico-legal protection, and professional accountability (1-3).

Although the overall level of awareness was satisfactory, variations were identified in specific aspects of orthodontic documentation according to age groups. Significant associations were observed regarding documentation of the degree of crowding, use of lateral cephalometric radiographs, and physical storage of dental models. Older orthodontists demonstrated more consistent practices in these areas compared with younger practitioners. This finding may be related to greater clinical experience and increased exposure to conventional comprehensive diagnostic protocols among senior practitioners (4,5).

In contrast, younger orthodontists may rely more frequently on selective documentation approaches depending on case complexity and available digital alternatives. The present findings also revealed that conventional handwritten record systems remain the predominant method of record maintenance among Iraqi orthodontists, whereas digital storage systems are still relatively underutilized. Despite the rapid global advancement of digital orthodontic technologies, including digital models, computerized records, and cone-beam computed tomography, the transition toward complete digitalization in local clinical practice appears limited (2,7-9).

Several factors may contribute to this limitation, including financial costs, insufficient technical infrastructure, limited training opportunities, and variable accessibility to digital systems in different clinical settings. From a medico-legal perspective, the majority of participants recognized the legal importance of maintaining orthodontic records. Accurate and comprehensive documentation is considered an essential component of risk management in orthodontic practice, particularly because orthodontic treatment usually extends over prolonged periods and requires continuous monitoring and follow-up (7,10-12).

Proper documentation protects both clinicians and patients by ensuring accurate communication, treatment transparency, and legal accountability. However, despite adequate awareness, some aspects of clinical implementation remain inconsistent, particularly regarding informed consent documentation, digital storage systems, and standardized record organization protocols. Regarding record retention and disposal practices, no statistically significant differences were identified among age groups. Most participants reported retaining patient records for extended periods, particularly in medico-legal cases. Nevertheless, the absence of standardized disposal protocols among many participants highlights an important gap in record management practices. Safe and ethical disposal of patient records is considered an important aspect of patient confidentiality and professional responsibility (11,12).

Therefore, the establishment of unified professional guidelines for record retention and disposal may improve the quality and legal reliability of orthodontic documentation practices.

Overall, the findings of the present study indicate that Iraqi orthodontists possess adequate awareness regarding orthodontic record-keeping principles; however, a noticeable gap persists between theoretical awareness and consistent clinical implementation. Continuous professional education programs, improved access to digital technologies, and the development of standardized national guidelines may contribute to enhancing the quality, efficiency, and medico-legal reliability of orthodontic record-keeping practices in contemporary orthodontics.

5. Limitations

Several limitations should be considered when interpreting the findings of this study. First, the cross-sectional design limits the ability to establish causal relationships between participants' characteristics and record-keeping practices. Second, data were collected using a self-administered questionnaire, which may be subject to recall bias and social desirability bias. Third, the use of purposive sampling and the relatively limited sample size may restrict the generalizability of the findings to all Iraqi orthodontists. In addition, variations in clinical experience, workplace settings, and access to digital technologies may have influenced participants' responses and record-management practices. Future studies involving larger, randomly selected samples and multiple practice settings are recommended to provide a more comprehensive assessment of orthodontic record-keeping practices.

Conclusions

Within the limitations of the present study, Iraqi orthodontists demonstrated generally adequate awareness regarding the principles and importance of orthodontic record-keeping. Significant age-related differences were observed in certain aspects of documentation and record organization, whereas record retention and disposal practices showed relatively similar patterns among different age groups. Despite the overall awareness of medico-legal responsibilities, variations in the practical implementation of standardized record-keeping procedures were identified, particularly regarding digital storage systems and documentation consistency. Therefore, the development of standardized professional guidelines, wider integration of digital technologies, and continuous professional education programs are recommended to improve the quality, efficiency, and legal reliability of orthodontic record-keeping practices in orthodontic care.

Ethics approval and consent to participate

The study was approved by the Ethics Committee of the College of Dentistry, University of Baghdad, Iraq. All participants voluntarily agreed and provided electronic informed consent prior to participation.

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Conflict of Interest

The authors declare no conflict of interest.

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Appendix

Questionnaire

<u>Part 1: General Information</u>

1. Age

2. Gender

   A. Male

   B. Female

3. Degree of Speciality

   A. MSc.

   B. Ph.D.

4. Did you practice your orthodontic specialty?

   A. Yes

   B. No

5. Your experience after getting the specialty degree

   A. Less than 2 years

   B. More than 2 years

Main Question: Do you document and maintain orthodontic records in your clinical practice?

A. Yes

B. No

Part 2: Documentation of Orthodontic Patient Records (History and Examination)

Tick the most significant information of patient records in your case sheet (History and Examination).

1. Patient Details: Name, address postcode, date of birth and parent/guardian telephone number.

   A. Never

   B. Sometimes

   C. Always

2. Informed Consent from patient/Parent/Guardian

   A. Never

   B. Sometimes

   C. Always

3. Medical History

   A. Never

   B. Sometimes

   C. Always

4. Oral Health Status

   A. Never

   B. Sometimes

C. Always

5. Orthodontic Charting

a. Skeletal pattern

A. Never

B. Sometimes

C. Always

b. Malocclusion classification

A. Never

B. Sometimes

C. Always

c. Overjet & Overbite

A. Never

B. Sometimes

C. Always

d. Degree of crowding

A. Never

B. Sometimes

C. Always

6. Radiographs

a. Lateral Cephalogram

A. Never

B. Sometimes

C. Always

b. OPG

A. Never

B. Sometimes

C. Always

c. Intraoral periapical radiograph

A. Never

B. Sometimes

C. Always

7. Photographs

a. Before treatment

A. Never

B. Sometimes

C. Always

b. During treatment (regular intervals)

A. Never

B. Sometimes

C. Always

c. After treatment

A. Never

B. Sometimes

C. Always

8. Dental Model

a. Before treatment

A. Never

B. Sometimes

C. Always

b. During treatment (regular intervals)

A. Never

B. Sometimes

C. Always

c. After treatment

A. Never

B. Sometimes

C. Always

9. Dental Model type

a. Digital dental models

A. Never

B. Sometimes

C. Always

b. Physical dental models

A. Never

B. Sometimes

C. Always

Part 3: Storage, Retention, and Maintenance of Orthodontic Records

1. Do you follow a regular system for the storage, maintenance, and retention of orthodontic records?

a. Yes

b. No

c. Sometimes

2. Do you think you are legally bound to maintain the records in your clinic?

a. Yes

b. No

c. Don't know

3. What methods are used for maintaining patient records in your dental practice? (You can choose more than one option)

a. Handwritten documentation

b. Printed forms

c. Electronic/digital records

4. How are the records stored?

a. By date

b. Alphabetical order

c. Customized serial number to the file

5. For how long do you store orthodontic records of ongoing/active and completed patients?

   a. Records are not retained

   b. Retention period < 1 year

   c. Retention period > 1 year

6. For how long do you store orthodontic records of non-reporting/inactive patients (not attending for 24 months)?

   a. Records are not retained

   b. Retention period < 1 year

   c. Retention period > 1 year

7. How long are patient files and other records of medico-legal cases retained?

   a. Not retained

   b. Less than 1 year

   c. More than 1 year

8. How are records disposed of after the retention period? (Select one option)

   a. Returned to patients

   b. Incineration or shredding

   c. Disposal through external agencies

   d. None of the above