



The last undocumented conversation in dentistry

Dentistry has spent a decade instrumenting the operator. The conversation that decides whether treatment actually happens is still going unrecorded — and it is the one that determines production.

Subject	The Treatment Coordinator Note as an operational data asset
Audience	Practice owners, office managers, DSO and group operations leadership
Evidence base	113 structured TC Notes captured in live practice, January–August 2026
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EXECUTIVE SUMMARY

What the notes reveal

A dental practice can diagnose perfectly, present clearly, and still lose the case in the ninety seconds after the doctor leaves the room. That handoff — from provider to treatment coordinator — is where the plan gets explained, priced, financed, objected to, scheduled, or quietly dropped. Until recently it left no record at all.

DentScribe Treatment Coordinator Notes capture that conversation and render it as structured data: treatment plan review, financial discussion, payment options, objection handling, emotional support, scheduling, and next steps. Once it is structured, it can be counted. This paper analyses 113 such notes from live practice and reports what became visible the moment the conversation stopped being invisible.

46% OF VISITS ENDED WITH NO APPOINTMENT RECORDED	36% NEVER MENTIONED A WAY TO PAY	21% STATED THE PATIENT'S OWN OUT-OF-POCKET FIGURE	6.2x BOOKING RATE OF COMPLETE VS. INCOMPLETE CONVERSATIONS
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The central finding is not that coordinators are performing badly. It is that they are performing *inconsistently*, and that nobody could previously see the pattern. Conversations that covered all five case-acceptance essentials booked at 62%. Conversations that covered three or fewer booked at 10%. The gap is not talent. It is whether a step happened.

SECTION 01

The gap everyone measures and nobody can see

Case acceptance is the most discussed metric in dental practice management and the least reliably measured. Published benchmarks vary widely depending on the denominator used — existing patients typically accept in the 40–50% range against 25–35% for new patients, with high performers reported between 70% and 90%. Measured by dollars rather than procedure counts, industry analytics put average acceptance of diagnosed treatment closer to 35–45%. The spread in the published numbers is itself the story: practices are measuring different things and calling them the same metric.

The financial consequence is well understood. A practice presenting \$1,000,000 in treatment annually at 50% acceptance collects half of it; the same practice at 80% collects \$300,000 more without adding a single new patient. Consultants working with multi-location groups consistently identify unscheduled treatment — care that was diagnosed, often verbally accepted, and never put on the calendar — as the largest single pool of recoverable production in a typical practice, with estimates that 40–60% of diagnosed treatment sits unscheduled at any given time.

What makes this leak uniquely difficult is that it never appears as a loss. A denied claim lands in an aging report. A missed call at least rang. A diagnosed case that was never scheduled simply ages quietly in the software, and no line item ever names the patient who was not followed up with. Production looks healthy while a substantial block of it decays week by week.

Every practice management system records what was *done*. Almost none record what was *said* — which is where the decision was actually made.

Practice management systems are transaction ledgers. They know the procedure code, the fee, the appointment, and the payment. They do not know that the patient said the cost was too high, that the coordinator offered financing and the patient declined it, that the patient wanted to speak to a spouse first, or that nobody ever asked for a date. Those facts determine the outcome and have historically existed only in a coordinator's memory.

SECTION 02

Why this became solvable in 2026

Three conditions converged. First, adoption crossed the threshold from experimental to operational: roughly a quarter to a third of US dental practices had adopted some form of AI by 2025, and a survey of 300 licensed dentists across Canada, the US and the UK conducted in early 2026 found about a third now using AI clinically, led overwhelmingly by radiograph interpretation at 82% of AI users. The global AI-in-dentistry market was valued at \$516.5 million in 2025 with projections approaching \$3.9 billion by 2035.

Second, ambient documentation matured. Industry leadership has begun forecasting the effective end of manual clinical note-taking, with ambient AI documentation becoming standard rather than novel. The technology to listen to a clinical encounter and produce a structured, reviewable note is no longer the hard part.

Third — and least discussed — the industry ran out of easy places to look. Imaging AI improved diagnosis. Recall automation improved the hygiene schedule. Neither touched the conversation between diagnosis and scheduling. The American Dental Association, in its 2026 submission to HHS on accelerating AI adoption, identified the heterogeneity

and poor interoperability of dental records as a principal constraint on the field, and specifically urged support for clinical documentation improvement. The bottleneck was never the model. It was that the most decision-relevant conversation in the practice produced no data at all.

SECTION 03

Anatomy of a Treatment Coordinator Note

A TC Note is a structured, factual summary of the post-appointment discussion, generated from what was actually said. It is not a transcript and not a marketing artifact. It is a record organised into consistent sections, which is what makes it countable across hundreds of conversations and dozens of coordinators.

SECTION	WHAT IT CAPTURES	WHY IT MATTERS OPERATIONALLY
Treatment plan review	What was recommended, sequencing, urgency, phased alternatives	Confirms the clinical plan survived the handoff intact
Financial discussion	Totals, insurance estimates, patient portion, amount due	The strongest predictor of a stalled decision is an unclear number
Payment options	Financing, membership plans, phasing, benefit timing, discounts	Inventories what the practice actually offers, versus what it thinks it offers
Objection handling	Hesitations raised and the response given	Turns anecdote into a ranked, coachable taxonomy
Emotional support	Reassurance, anxiety management, post-op guidance, comfort measures	The patient-care dimension that never appears in a procedure code
Scheduling	Dates offered, dates booked, preferences, constraints	Distinguishes “patient declined” from “nobody asked”
Next steps	Commitments by the office and by the patient	The recoverable follow-up list, made explicit

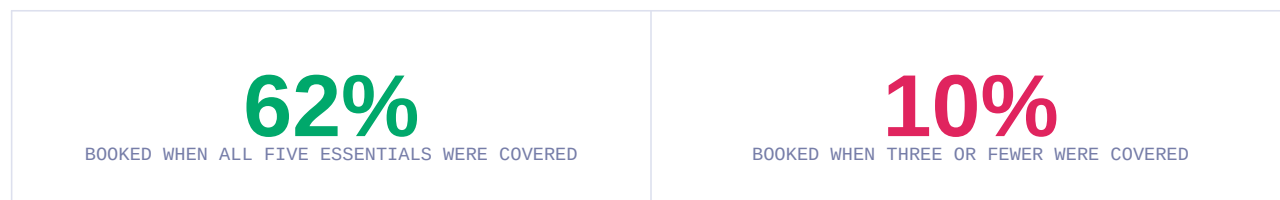
The design decision that makes this useful is the fixed schema. A free-text note is a memory aid for one person. A sectioned note is a dataset. The difference is whether an owner can ask, across four hundred conversations, “how often did we present a payment option before the patient objected?” and get an answer.

SECTION 04

Field evidence: 113 conversations

The analysis below covers 113 TC Notes captured in live practice between January and August 2026, spanning 49 coordinator identifiers and a full range of procedure types from hygiene recall through implant cases. Five test entries were excluded. Every note parsed against the consistent seven-section schema.

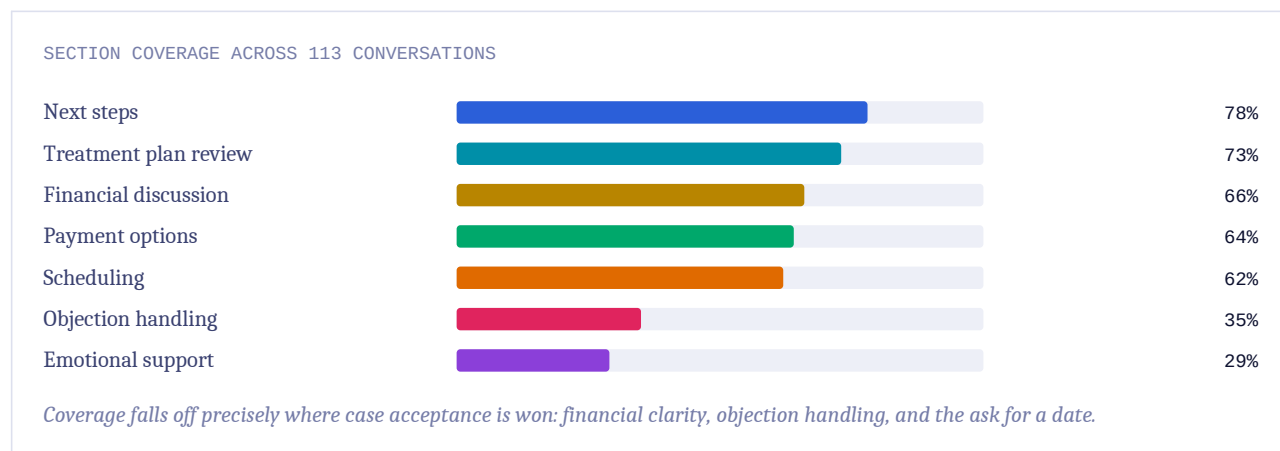
Finding 1 — Completeness predicts booking, sharply



Conversations covering all five case-acceptance essentials — plan, financials, payment options, scheduling, next steps — booked at 62%. Those covering three or fewer booked at 10%. Only 37% of conversations were complete on this measure; 23% covered two or fewer.

This is a correlation and should be read as one. A conversation that goes well is more likely to reach every section, so completeness partly reflects a good outcome rather than causing it. But the mechanism runs in both directions, and one direction is directly actionable: a scheduling conversation that never occurs cannot produce an appointment.

Finding 2 — The most common failure is silence, not refusal

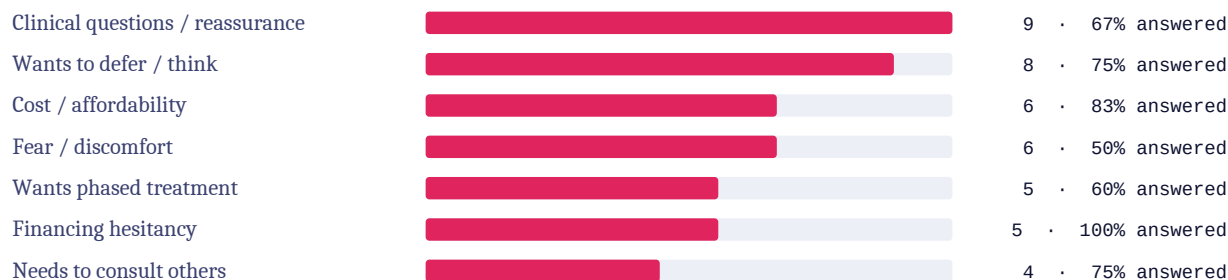


Forty-six percent of conversations ended with no appointment of any kind recorded, and 38% contained no scheduling discussion at all — not a declined appointment, simply no attempt documented. Seven conversations reviewed a treatment plan *and* quoted a specific price, then closed without any move toward a date. That is the cheapest available production in any practice: the patient is already in the chair and already knows the number.

Across the sample, \$137,834 of treatment value was quoted. Of that, \$65,696 sat in conversations that ended unresolved. These are not lost patients. They are diagnosed, priced, and warm — the highest-converting outreach list a practice owns, and one that decays fastest in the first week.

Finding 3 — The friction taxonomy is not what practices assume

PATIENT FRICTION BY FREQUENCY, AND THE SHARE ANSWERED WITH A CONCRETE LEVER



Cost ranks third. The two most frequent forms of friction are answerable with words rather than discounts — and the least-answered category is fear.

This inverts the standard assumption. Practices build their objection training around money, and the population-level data supports that instinct — consumer research consistently finds cost the leading reason Americans delay dental care, with one 2026 study reporting that 92% would consider holding off on general dental care because of cost. But at the chairside, in the specific moment of the TC conversation, the friction that appears most often is a patient asking a clarifying question and looking for reassurance, followed by a patient who simply wants time.

Both are answerable without touching the fee. Neither is being reliably answered: objection handling was documented in only 35% of conversations, and 18 conversations recorded friction with no lever offered in response at all.

The least-answered category is the one with the strongest evidence base behind it. A census-matched JADA survey of 1,003 US adults found 72.6% reported some fear of the dentist, with 26.8% describing it as severe. In this dataset, fear and discomfort were answered with a documented response only half the time — the lowest rate of any friction type.

Finding 4 — Money is discussed in the practice's units, not the patient's

Only 21% of notes stated the patient's own out-of-pocket figure. Totals and insurance estimates appeared far more often. The distinction matters because the patient is not deciding on a \$843 treatment total or a \$552.60 insurance estimate; they are deciding on the \$290.40 they will hand over on the day. Group-practice research has made the same observation from the other direction: when patients leave the operatory without a clear price, the decision stalls and acceptance slips quietly.

The notes also surface a recurring surprise-billing risk that no procedure code would capture — in-network status changing mid-plan, annual maximums about to be exhausted, insurers sending reimbursement directly to the patient rather than the office. Each of those is a satisfaction event waiting to happen, and each is visible in the note weeks before it becomes a phone call.

Finding 5 — The follow-up ledger exists but has no owner

The office made 98 explicit commitments across these conversations — calendar invites, callbacks, insurance verifications, claim follow-ups, scanned paperwork. Roughly one per visit. Not one carried an owner or a due date in the note. Meanwhile 22% of conversations closed with no documented next step for either side.

Follow-up timing research is unambiguous on the cost of that: the highest-converting first contact after an unscheduled plan happens within 48 to 72 hours, while the diagnosis still feels relevant. An unowned commitment

made on Tuesday is usually a cold case by the following Monday.

Finding 6 — Reassurance is treated as a personality trait, not a step

Emotional and motivational support appeared in 29% of conversations. Where it appeared, the content was genuinely good: post-operative guidance, comfort measures, hygiene praise, handling a patient's fear of the needle, explaining what recovery would feel like. Conversations including it booked at 39% against 31% for those without.

The point is not the differential, which is modest and confounded. The point is that a practice with a real patient-care advantage was delivering it about a third of the time and had no way to know that.

SECTION 05

Five classes of insight the TC Note unlocks

Generalising from the above, structured TC Notes produce five categories of intelligence that were previously unavailable at any price.

1. **Conversation coverage.** Which steps happened, per coordinator, per location, per procedure type. This is the closest thing dentistry has to a process-compliance measure for case acceptance, and it is coachable in a way that an acceptance percentage is not. “Your acceptance is 41%” is a verdict. “You presented a payment option in three of your last twenty conversations” is an instruction.
2. **A ranked friction taxonomy.** Not what the practice believes patients object to, but what they actually said, ordered by frequency and paired with whether anyone answered. This turns objection training from generic scripting into a targeted exercise against the practice's own top four.
3. **A lever inventory.** What the practice actually reaches for. In this dataset third-party financing and discounts dominated, in-house payment plans appeared three times, and several notes stated outright that payment plans were no longer offered — removing the one lever that does not depend on a credit check. That is a strategic finding no one had written down.
4. **A commitment ledger.** Every promise made, extractable as a task list. This is the fastest payback in the entire dataset because it requires no behaviour change from anyone — only routing.
5. **Financial-clarity auditing.** Whether the patient was given the number they were actually deciding on, and whether foreseeable billing surprises were flagged in advance. This is a patient-satisfaction instrument and a review-management instrument at the same time.

THE REFRAME

Case acceptance has always been managed as an *outcome* metric — measured after the fact, attributed to talent, addressed with training. Structured TC Notes make it a *process* metric: a sequence of steps that either occurred or did not, observable per conversation, correctable the same week. Outcomes are argued about. Process is fixed.

SECTION 06

From insight to operating rhythm

Data that is not on a calendar changes nothing. The following rhythm converts TC Note intelligence into production without adding headcount.

Daily — the commitment sweep

Every office-side commitment captured in yesterday's notes is assigned an owner and a due date before the morning huddle ends. Invites, callbacks, insurance checks, claim questions. This is pure recovery; nothing is being asked of anyone that was not already promised to a patient.

Weekly — the open-quote list

Every conversation where a treatment total was quoted and no appointment was booked goes onto a structured re-contact list, worked within 72 hours. The opening line is the clinical consequence of delay, not the price. Notes in this dataset already document coordinators explaining that fees and coverage change when treatment is postponed — that is the message, and it is true.

Weekly — one coaching conversation, one metric

Coverage is reviewed per coordinator against a single chosen step. Not a scorecard review; one step. Practices that try to fix all seven sections at once fix none. Where note volume per coordinator is thin — 41 of 49 identifiers in this dataset had fewer than three notes — read the aggregate, not the individual.

Monthly — the friction review and the lever audit

The top four friction categories are reviewed and scripted responses agreed for each. Separately, the lever inventory is checked against what the practice intends to offer. A practice that believes it offers phased treatment and finds it documented four times in eight months has a training gap or a policy gap, and the note tells it which.

Quarterly — financial-clarity audit

Sample the notes and ask a single question of each: did this patient leave knowing what they would pay on the day of service? The target is a number close to 100%, and the current baseline in this dataset is 21%.

SECTION 07

A revised KPI set

The metrics below are directly derivable from structured TC Notes and are proposed as a supplement to, not a replacement for, existing acceptance reporting.

METRIC	DEFINITION	OBSERVED	BASELINE
Conversation coverage	Share of TC conversations covering all five case-acceptance essentials	37%	
Ask rate	Share of conversations containing a scheduling discussion	62%	
Payment-option presentation	Share where at least one payment mechanism was presented	64%	

METRIC	DEFINITION	OBSERVED BASELINE
Objection answer rate	Share of documented friction met with a concrete lever	50–100% by type
Financial clarity	Share stating the patient's own out-of-pocket amount	21%
Open quoted value	Treatment dollars quoted in conversations that ended unbooked	\$65,696 of \$137,834
Commitment closure	Share of office-side promises completed within their stated window	Not yet measurable

The final row is the most important one on the page. It cannot be computed from notes alone — it requires the commitment to be routed to a task system and closed out. That integration is where the next tranche of production sits.

SECTION 08

Governance, and honest limits

A paper that only lists benefits should not be trusted. Four constraints apply directly to the findings above.

This measures documentation, not reality. “No appointment recorded” means the note contains no booking signal. It does not prove no appointment was made. Early in adoption, a low coverage score may reflect note-taking habits rather than conversation quality — which is itself worth fixing, but should not be mistaken for a coaching finding. The corrective is to read trends after the documentation habit stabilises, not in week one.

Attribution needs volume. Coordinator identifiers in this dataset were free-text initials, producing 49 distinct entries of which only 8 carried three or more notes. Per-person performance conclusions require a real identity model and a meaningful sample. Practices should resist ranking staff on thin data.

Extracted figures are dictated figures. At least one note in this sample rendered a filling total as \$7.08 against a \$621.80 insurance estimate — an obvious transcription slip. Aggregate treatment value is an order-of-magnitude indicator for prioritising follow-up, not an accounting figure, and should never be reconciled against the ledger as though it were one.

Privacy and scope are not optional. These notes contain protected health information and financial detail. They belong inside systems with a signed business associate agreement, encryption in transit and at rest, and a contractual guarantee that patient data is not used for model training. The ADA's own submission on AI adoption stressed validated datasets and independent evaluation frameworks as prerequisites for trustworthy clinical AI; the same standard should apply to operational AI. And the boundary holds: these notes support documentation, coaching, and follow-up. They do not diagnose, do not establish medical necessity, and do not replace the dentist's judgment or the informed-consent conversation.

The goal is not to score coordinators. It is to stop asking people to remember a seven-step conversation forty times a week without a checklist.

SECTION 09

Conclusion

Dentistry's productivity conversation has focused for a decade on the operator: better imaging, faster charting, fewer hours spent documenting after close. That work matters and it is largely being won. But the practice does not lose most of its production in the operator. It loses it in the corridor afterwards, in a conversation that until recently no system observed.

The evidence in this paper is drawn from a single sample and should be treated accordingly. What it demonstrates is not a universal benchmark but a capability: once the post-appointment conversation is structured, ordinary operational questions become answerable. How often do we ask for the date? What do our patients actually push back on? What do we offer when they do? What did we promise, and did anyone do it?

None of those questions require a new patient, a new operator, or a new marketing spend. They require only that the conversation stops disappearing. In this dataset, complete conversations booked six times more often than incomplete ones. That is the entire argument.

APPENDIX

Method

113 structured TC Notes captured in live practice between January and August 2026 were analysed. Five test or dummy entries were excluded from all figures. Each note was parsed against the seven-section schema, and rule-based classification was applied to identify procedure types, friction categories, payment and scheduling levers, outcome signals, and stated dollar figures. Coverage was scored as the mean presence of the five sections most directly tied to case acceptance; objection handling and emotional support were tracked but excluded from the score, since neither is expected in every visit. Approximately 10% of detected friction resisted classification and was retained as its own category rather than discarded. Outcome was inferred from scheduling and next-steps language. Coordinator identifiers were normalised for obvious duplicates. All findings are descriptive; no causal claims are made.

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DentScribe · Treatment Coordinator Intelligence · August 2026. Findings are descriptive and drawn from a single 113-note sample. Benchmarks cited from third-party sources reflect those publications' own methodologies, which vary. This document supports documentation, coaching and follow-up workflows. It is not clinical guidance.