



# MINNESOTA BOARD OF DENTISTRY

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## RECORDKEEPING

revised November 20, 2007

### REGULATIONS

This issue is regulated by Minnesota Rule [3100.9600](#). The exact language can be found at the Board of Dentistry web site by clicking on the link "statutes and rules" or the link "other."

### BACKGROUND

The Board's recordkeeping rule establishes the *minimum* standard for maintaining dental records. The items addressed in the 14 subparts of the rule comprise what is minimally acceptable... certainly records that are more comprehensive would be preferred.

*Why is it necessary to set a standard?*

The fundamental concern is that the dentist must maintain a record for each patient that *accurately* and *legibly* documents all the dental care rendered and reasons for providing that care. Comprehensive documentation of the he chronology of care for each patient supports the decisions that were made and provides a record of the care that was both proposed and provided. A good record protects the patient and the provider. A dentist's recollection of events or existence of a standard protocol is not likely to be adequate for a subsequent provider, a Board committee, an insurance claims review, or a jury. The Board has adopted the philosophy that "*if it is not written down, it did not happen.*" It is always better for the provider to **document everything** as if someone else is reading the record, and the information is so understandable that there would be no doubt as to what occurred and why.

### COMMON INFRACTIONS

Common recordkeeping errors seen by the Board include, but are not limited to:

- not initially obtaining or updating a patient's personal data (subpart 3)
- not documenting the patient's concerns and complaints, i.e. their reason for the appointment (subp 4)
- not initially documenting or updating the patient's medical and dental histories (subp 5)
- not documenting results of the patient's examination, radiographs, and tests (subp 6)
- not documenting a reason for rendering care, such as: caries, defective restoration, cracks, open contacts, broken cusp, etc. (subp 7)
- not providing a dated and written treatment plan after each examination, preferably including costs and signed by the patient (subp 8)
- not documenting that the patient agreed to a specific treatment after being given the options, benefits and risks of each, and prognosis (subp 9)
- not fully documenting what occurred at every visit, such as: type and amount of local anesthesia, concentration and time of nitrous oxide, all materials used, prescription directions, refusal of recommended treatment, complications, etc. (subp 10)
- not documenting in the progress notes all contacts with or about the patient, such as but not limited to: phone calls, chance meetings or discussions, consultations with other practitioners, letters, e-mails, faxes, etc. (subp 10)
- not signing or initialing all entries in the progress notes (subp 10)
- including improper corrections to the record (subp 11)
- disposing of patient records or components of the records prematurely (subp 12)
- not promptly transferring records (subp 13) ...A dentist may *not* refuse to copy and transfer records, *even* if the patient owes money for previous treatment or does not agree to pay in advance the costs of duplication. See MN Statute §[144.291-.298](#) for details.

**NOTE: RADIOGRAPHS (AND COPIES MADE FOR TRANSFER) SHOULD BE OF DIAGNOSTIC QUALITY AND ACCURATELY LABELED!**

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