

## RECORDKEEPING CHECKLIST

PATIENT INITIALS: \_\_\_\_\_

DATES OF  
SERVICES REVIEWED: \_\_\_\_\_

### **Minnesota Rules 3100.9600 Record Keeping**

Subpart 1. DEFINITIONS.

For the purposes of this part, "patient" means a natural person who has received dental treatment from a provider. In the case of a minor who has received dental treatment pursuant to Minnesota Statutes, sections 144.341 to 144.347, the patient includes a parent or guardian.

Subp. 2. DENTAL RECORDS. Maintain dental records on each patient as specified in subparts 3 to 10.	<i><b>Present</b></i>	<i><b>Not Present</b></i>	<i><b>Not Applicable</b></i>	<i><b>Comments</b></i>
Subp. 3. PERSONAL DATA. A. Name. B. Address. C. Date of birth. D. If minor, name of parent or guardian. E. Emergency contact name and phone. F. Insurance information.				
Subp. 4. REASON FOR VISIT.				
Subp. 5. DENTAL HISTORY. Information must include sufficient data to support the recommended treatment plan.  MEDICAL HISTORY. Information must include sufficient data to support the recommended treatment plan.  The dental and medical history must be updated to reflect the current status of the patient.				
Subp. 6. CLINICAL EXAM INFORMATION. A. Record of existing oral health status. B. Radiographs used. C. Results of other diagnostic aids used.				
Subp. 7. DIAGNOSIS.				
Subp. 8. TREATMENT PLAN. • Agreed upon.  • Written and dated for <u>non</u> -routine care.  • Updated to reflect current status of patient's oral health / treatment.				
Subp. 9. INFORMED CONSENT. A. Licensee discusses treatment options, prognosis, benefits, and risks of treatment within their scope of practice.  B. The patient consents to treatment chosen.				

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Subp. 10. PROGRESS NOTES.				
<ul style="list-style-type: none"> <li>Legible and written in ink.</li> <li>Chronology of treatment / visits.</li> </ul>				
A. All treatment provided.				
B. All medications and anesthetics used.				
C. All dental materials placed.				
D. Treatment provider by license number, name, or initials.				
E. When applicable, identity of collaborating dentist authorizing treatment by license number.				
F. Administration information for nitrous oxide inhalation analgesia, including indication for use, dosage, duration of administration, post treatment oxygenation period prior to discharge, and patient status at discharge.				
Subp. 11. AMENDMENTS TO RECORDS.				
<ul style="list-style-type: none"> <li>In written record, amend record by crossing out with one single line and initialed by provider.</li> <li>In electronic record, amended record must be electronically time and date stamped by provider.</li> </ul>				
Subp. 12. RETENTION OF RECORDS.				
<ul style="list-style-type: none"> <li><u>Adult patient-active file</u>: maintain entire dental record.</li> <li><u>Adult patient-inactive file</u>: maintain dental record for at least seven years beyond the last date of treatment by the dentist.</li> <li><u>Minor patient-active file</u>: maintain entire dental record.</li> <li><u>Minor patient-inactive file</u>: maintain dental record until patient is 25 years old.</li> </ul>				
Subp. 13. TRANSFER OF RECORDS.				
<ul style="list-style-type: none"> <li>Transfer in compliance with Minn. Stat. 144.291 to 144.298 irrespective of status of patient's account.</li> <li>Digital radiographs on compact or optical disc, or electronic communication.</li> <li>All transferred film or digital radiographs must reveal images of diagnostic quality.</li> <li>Radiographs and photographs used must include date the image was taken and patient's name.</li> </ul>				
Subp. 14. ELECTRONIC RECORDKEEPING.				
<ul style="list-style-type: none"> <li>All subparts 1 to 13 apply to electronic record keeping as well as to record keeping by any other means.</li> <li>When electronic records are kept, a dentist must use an unalterable electronic record.</li> </ul>				