SUBCHAPTER 16T – PATIENT RECORDS

SECTION .0100 – PATIENT RECORDS

21 NCAC 16T .0101 RECORD CONTENT

A dentist shall maintain treatment records on all patients for a period of 10 years from the last treatment date, except that work orders must only be maintained for a period of two years. Treatment records may include such information as the dentist deems appropriate but shall include:

(1) the patient's full name, address, and treatment dates;
(2) the patient's emergency contact or responsible party;
(3) a current health history;
(4) the diagnosis of condition;
(5) the treatment rendered and by whom;
(6) the name and strength of any medications prescribed, dispensed, or administered along with the quantity and date provided;
(7) the work orders issued;
(8) the treatment plans for patients of record, except that treatment plans are not required for patients seen only on an emergency basis;
(9) the diagnostic radiographs, orthodontic study models, and other diagnostic aids, if taken;
(10) the patient's financial records and copies of all insurance claim forms;
(11) the rationale for prescribing each narcotic; and
(12) A written record that the patient gave informed consent consistent with Rule .0103 of this Section.

History Note: *Authority G.S. 90-28; 90-48;*
Eff. October 1, 1996;
Amended Eff. May 1, 2016; July 1, 2015;
Readopted Eff. January 1, 2019.