

**BOARD OF DENTISTRY
DENTAL RECORDS TASK FORCE AGENDA
VIA TELEPHONE CONFERENCE CALL
OCTOBER 22, 2013
6:00 P.M. EDT**

Call In Number (888) 670-3525, Participant Pass Code: 5805370981

- I. CALL TO ORDER/ROLL CALL**
- II. ITEM FOR TOPIC DISCUSSION**
 - A. Rule Draft 64B5-17.002, FAC**
- III. OLD BUSINESS**
- IV. NEW BUSINESS**
- V. ADJOURNMENT**

***To connect to the conference call, dial the following number: 888-670-3525 a minute or two prior to the start time of the meeting. You will then be prompted to enter a "participant pass code", which is 5805370981, followed by the # sign.**

Please mute your line. Press *6 to mute/unmute the line.

64B5-17.002 Written Dental Records; Minimum Content; Retention.

(1) For the purpose of implementing the provisions of subsection 466.028(1)(m), F.S., a dentist shall maintain written records on each patient which written records shall contain, at a minimum, the following information about the patient:

(a) Appropriate medical history including any current or previous medical condition, surgeries, hospitalizations, medications, and blood pressure

i. Medical history reviewed and updated at each appointment

ii. Blood pressure readings updated annually and prior to surgical procedures

iii. Blood pressure readings taken prior to any invasive procedure for patients previously diagnosed with hypertension:

(b) Results of clinical examination and tests conducted, including the identification, or lack thereof, of any oral pathology or diseases to include:

i. Charting of all existing dental restorations

ii. Charting of all existing dental pathology

iii. Evaluation of the Temporomandibular Joint (TMJ) and occlusion

iv. Periodontal evaluation including periodontal probing, evaluation of supporting bone, tooth mobility and presence of gingival inflammation and infection

v. Intraoral and extraoral Cancer Screening;

(c) Any radiographs used for the diagnosis or treatment of the patient to include:

i. Intraoral and extraoral radiographs needed to enable and support appropriate diagnosis

ii. Full mouth series, Panoramic, Cone Beam, Cephalometric, Bitewing, and Periapical radiographs taken at regular intervals.

iii. Limited radiographs for treating emergency patients;

(d) Treatment plan and treatment options proposed by the dentist; ~~and~~

(e) Treatment rendered to the patient.

i. Type and amount of local anesthesia used

ii. Type and shade of restorative material used

iii. Preoperative or postoperative medications prescribed

iv. Radiographs taken

v. Impression material and type of impression taken (i.e. maxillary, mandibular, interocclusal, digital, etc.)

vi. Medicaments, medications, sutures, irrigants, or bases applied to teeth or periodontal tissues

vii. Names or initials of all staff involved with clinical care of patient

viii. Use of dental barrier or rubber dam

ix. Unusual or unexpected events or reactions noted during or after procedure

x. Tooth number or tooth name treated

xi. Working length, canals treated, master apical files, obturation materials used during endodontic procedures;

(f) Consent.

i. General consent permitting dentist to provide dental care.

ii. Specific informed consent discussing expected outcomes and potential complications, risks, and need for additional treatment for procedures with higher associated risk. (i.e. Surgical, endodontic, orthodontic procedures); and

(g) Whenever patient records are released or transferred, the dentist releasing or transferring the records shall maintain either the original records or copies thereof and a notation shall be made in the retained records indicating to whom the records were released or transferred. However, whenever patient records are released or transferred directly to another Florida licensed dentist, it is sufficient for the releasing or transferring dentist to maintain a listing of each patient whose records have been so released or transferred which listing also includes the dentist to whom such records were released or transferred. Such listing shall be maintained for a period of 4 years. **Transfer of records in a multipractice dental office shall be done and documented in strict accordance with s. 466.018, F.S.**

(2) In order that the patients may have meaningful access to their dental records pursuant to subsections 466.028(1)(m) and (n), F.S., a dentist shall maintain the written dental record of a patient for a period of at least four (4) years from the date the patient was last examined or treated by the dentist. However, upon the death of the dentist, the retention provisions of Rule 64B5-17.001, F.A.C., are controlling.

(3) Each licensed dentist in Florida shall retain a copy of each entry in his or her patient appointment book or such other log, calendar, book, file or computer data, used in lieu of an appointment book for a period of no less than 4 years from the date of each entry thereon.

(4) The records required above and any other patient records shall be properly annotated to identify the dentist of record. The dentist of record is the dentist who:

(a) Is noted in the patient record as the dentist of record; or

(b) Provides a treatment or service and is noted in the patient record as the dentist of record for that treatment or service; or

(c) If there has been more than one provider of treatment, is the dentist who places the final restoration, does the surgical procedure, makes the diagnosis or finishes the service or procedure in question; or

(d) If there has been more than one provider of treatment and neither paragraph (a) nor (b) can be determined with reasonable certainty, is the owner dentist of the practice in which the dental patient was seen or treated.

(5) All dental records required by this rule and any additional records maintained in the course of practicing dentistry shall be the property of the owner dentist of the dental practice in which the dental patient is seen or treated and the owner dentist shall be ultimately responsible for all record keeping requirements set forth by statute or rule.

(a) The owner dentist is responsible for the records of patients seen or treated by any employee, associate or visiting dentists.

(b) Multiple owners will be held equally responsible for the records of patients seen or treated within the dental practice of that dental group.

(c) An owner dentist is not responsible for the records of an independent dentist who is merely leasing or renting space or services for the operation of a separate dental practice.

(6) Patient records may be kept in an electronic data format, provided that the dentist maintains a back-up copy of information stored in the data processing system using disk, tape or other electronic back-up system and that said back-up is updated on a regular basis, at least weekly, to assure that data is not lost due to system failure. Any electronic data system must be capable of producing a hard copy on demand.

(7) Limited Screenings, Examinations and Treatments: The Board of Dentistry encourages the provision of pro-bono dental screenings services through organized events such as Dental Health Screenings and Give Kids a Smile Program. A strict interpretation of this rule would preclude such efforts to the detriment of the public. Therefore, the Board deems that any records generated as a result of such limited, one-time pro-bono dental screenings, examinations, or treatments through organized events, should be consistent with the nature and scope of the services rendered, should be provided to the recipient or guardian and will not result in the dentist performing such services becoming the dentist of record. The minimum content and record retention set forth in subsection (1) above shall not be required. When the the dentist performs such examinations or treatments each recipients or guardian shall be informed in writing of the following:

(a) The limitation of the screening to one-time dental examination and treatment that can reasonably be performed on the same day of screening. In addition, such examinations or treatments would not reasonably require follow-up treatment;

(b) The results of the screening examination or treatments; and

(c) That the screening is not representative of or a substitute for a comprehensive dental exam.

Rulemaking Authority 466.004(4) FS. Law Implemented 456.058, 466.028(1)(m), (o) FS. History—New 10-8-85, Formerly 21G-17.02, Amended 10-28-91, Formerly 21G-17.002, Amended 11-22-93, Formerly 61F5-17.002, 59Q-17.002, Amended 11-15-99, 4-22-03, 3-14-13, _____.