

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.