Record Keeping Requirements
CODE OF COLORADO REGULATIONS
3 CCR 709-1
Colorado Dental Board

Please scroll down to Rule
IX. Record Keeping Requirements

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(Amended December 2, 2002; Re-numbered December 30, 2011; Amended January 22, 2015, Effective March 30, 2015; Amended April 28, 2016, Effective June 30, 2016)

A. Treatment Provider Identification

1. Patient records shall note at the time of the treatment or service the name of any dentist, dental hygienist, or dental assistant who performs any treatment or service upon a patient.

2. When patient treatment or service is performed which requires supervision, the patient record must also note the name of the supervising dentist for the treatment or service performed on the patient.

B. Access to Patient Records

1. A patient's record in the custody of a dentist or dental hygienist, dental or dental hygiene practice (treatment provider no longer works there), or other entity (treatment provider no longer has access to the records through bankruptcy, foreclosure, eviction, etc.), shall be available to a patient, the patient's designated representative ("representative"), or any former treatment provider during normal business hours within 7 calendar days. The custodian of the record shall make a copy of the record available or make the record available for inspection within 7 calendar days.

2. The patient record does not include a "doctor's office notes" as defined in Rule I(E).

3. A patient, representative, or any former treatment provider may inspect or obtain a copy of the patient record after submitting a signed and dated request to the custodian of the patient record. The provider or the custodian of record shall acknowledge in writing the patient's, representative's, or any former treatment provider's request. If an inspection of the record occurred, the patient, representative, or any former treatment provider shall sign and date the record to acknowledge inspection.

4. A patient, representative, or any former treatment provider may not be charged for inspection of records.

5. Records may not be withheld for past due fees relating to dental treatment.

6. The patient, representative, or any former treatment provider shall pay for the reasonable cost of obtaining a copy of the patient record, not to exceed the actual cost of the medium and shall not be charged any labor fees. Actual postage costs may also be charged.

7. Pursuant to section 25-1-802(1)(b)(I)(B), C.R.S., if the patient's original records are stored and readily producible in electronic format and the patient, representative, or any former treatment provider requests it in that format, then the custodian of records must provide it electronically.

8. If the patient, representative, or any former treatment provider so approves, the custodian may supply a written interpretation by the attending provider or representative of patient records, such as radiographs, diagnostic casts, or non-written records which cannot be reproduced without special equipment. If the requestor prefers to obtain a copy of such patient records, the requestor must pay the actual cost of such reproduction.

9. If changes, corrections, deletions, or other modifications are made to any portion of a patient record, the person must note in the record date, time, nature, reason, correction, deletion, or other modification, and his/her name. If records are electronic they must be date-stamped without the ability to be subsequently altered.

10. Nothing in this rule shall be construed to limit a right to inspect patient records that is otherwise granted by state statute to the patient, representative, or any former treatment provider.

11. Nothing in this rule shall be construed to waive the responsibility of a custodian of records to maintain confidentiality of those records in the possession of the custodian.

C. Examination, Diagnosis, and Documentation

Prior to initiating a dental exam, a licensee must establish and document the reason for the patient's visit in order to clearly identify an appropriate type of exam. All relevant findings and periodontal diagnosis must be documented, if applicable, including a finding of WNL (within normal limits), indicating that an evaluation took place.

1. The comprehensive exam – if the patient desires a comprehensive exam, then the following components are required to be documented in order to appropriately evaluate the patient's dental status:

   a. Obtaining a relevant medical and dental history;

   b. Conducting a thorough clinical and radiographic examination (within ALARA guidelines) with evaluation of extraoral and intraoral structures;

   c. Oral cancer screening;

   d. Assessment of any prosthesis; and

   e. Complete periodontal charting for adult patients.

2. The limited exam – if a referring dentist, dental hygienist, other health care professional, or the patient is requesting an examination for an emergency condition or specific area of concern, then the examination can be limited to the specific problem and the following components are required to be documented in order to appropriately evaluate the patient's dental status:

   a. Obtaining a relevant medical and dental history;

   b. Conducting a thorough clinical and radiographic examination (within ALARA guidelines) of the area of concern and evaluation of extraoral and intraoral structures in the area of concern;

   c. Assessment of any prosthesis as it relates to the area of concern; and

   d. Periodontal charting in the area of concern, unless not clinically indicated.

3. The periodic exam – if treating a patient for follow-up/maintenance care, then the following components are required to be documented in order to appropriately evaluate the patient's dental status:

   a. Obtaining a relevant medical and dental history;

   b. Conducting a thorough clinical and radiographic examination (within ALARA guidelines) with evaluation of extraoral and intraoral structures as clinically indicated;

   c. Oral cancer screening;

   d. Assessment of any prosthesis; and

   e. Periodontal charting, including a full periodontal charting (examination) every 12-18 months.

4. Periodontal exam/diagnosis – a licensee is required to document the following components in the patient record:

    a. At a minimum, the following current diagnostic information is required in order to diagnose the periodontal condition of the patient:

        i. Periodontal measurements for the teeth to be treated.

        ii. Radiographs, which demonstrate the crestal bone.

        iii. Bleeding upon probing data for the areas to be treated.

    b. If periodontal therapy has been performed, a licensee is required to conduct a follow-up exam to evaluate and inform the patient of his/her response to the therapy, and to discuss any further treatment that may be necessary, including but not limited to, the referral to a dentist qualified and trained to treat advanced periodontal disease.

5. Root canal therapy procedure – if performing one, a licensee is required to document use of a rubber dam.

6. A licensee must document in the patient's record:

    a. Discussion of recommended treatment as well as alternatives, risks, benefits, and prognosis.

    b. Timely referral for any needed specialist care.

    c. Patient's election for treatment. If the treatment elected by the patient differs from the recommended treatment and/or sequence, then the licensee must document the reason for the deviation of the recommended course of treatment and/or sequence. If proceeding with the patient's elected deviation does not cause harm, then the licensee must retain documentation supporting the request to deviate from the recommended course of treatment and/or sequence.

    d. If a patient declines recommended treatment.

    e. A rationale for omission of or exception from any required component.

    f. If verbal consent is obtained prior to treatment.

7. All prescriptions shall bear:

    a. Full name and date of birth of patient;

    b. Drug name, strength, and dosage form;

    c. Quantity prescribed;

    d. Directions for use;

    e. Authorized refills, if applicable; and

    f. Name and address of prescribing dentist.