WAC 246-817-305 Patient record content. (1) A licensed dentist who treats patients shall maintain legible, complete, and accurate patient records.

(2) The patient record must contain the clinical records and the financial records.

(3) The clinical record must include at least the following information:

(a) For each clinical record entry note, the signature, initials, or electronic verification of the individual making the entry note;

(b) For each clinical record entry note, identify who provided treatment if treatment was provided;

(c) The date of each patient record entry, document, radiograph or model;

(d) The physical examination findings documented by subjective complaints, objective findings, an assessment or diagnosis of the patient's condition, and plan;

(e) A treatment plan based on the assessment or diagnosis of the patient's condition;

(f) Up-to-date dental and medical history that may affect dental treatment;

(g) Any diagnostic aid used including, but not limited to, images, radiographs, and test results. Retention of molds or study models is at the discretion of the practitioner, except for molds or study models for orthodontia or full mouth reconstruction which shall be retained as listed in WAC 246-817-310;

(h) A complete description of all treatment/procedures administered at each visit;

(i) An accurate record of any medication(s) administered, prescribed or dispensed including:

(i) The date prescribed or the date dispensed;

(ii) The name of the patient prescribed or dispensed to;

(iii) The name of the medication; and

(iv) The dosage and amount of the medication prescribed or dispensed, including refills.

(j) Referrals and any communication to and from any health care provider;

(k) Notation of communication to or from the patient or patient's parent or guardian, including:

(i) Notation of the informed consent discussion. This is a discussion of potential risk(s) and benefit(s) of proposed treatment, recommended tests, and alternatives to treatment, including no treatment or tests;

(ii) Notation of posttreatment instructions or reference to an instruction pamphlet given to the patient;

(iii) Notation regarding patient complaints or concerns associated with treatment, this includes complaints or concerns obtained in person, by phone call, email, mail, or text; and

(iv) Termination of doctor-patient relationship; and

(l) A copy of each laboratory referral retained for three years as required in RCW 18.32.655.

(4) Clinical record entries must not be erased or deleted from the record.

(a) Mistaken handwritten entries must be corrected with a single line drawn through the incorrect information. New or corrected information must be initialed and dated.

(b) If the record is an electronic record then a record audit trail must be maintained with the record that includes a time and date

history of deletions, edits and/or corrections to electronically signed records.

[Statutory Authority: RCW 18.32.0365, 18.32.655, and 18.32.002. WSR 16-07-084, § 246-817-305, filed 3/17/16, effective 4/17/16.]