(4) Records

(a) All registrants, professional corporations, and facilities shall maintain full and complete clinical dental records on behalf of themselves and all other dentists and dental professionals in their employ. These records shall include as a minimum the following information:

- (i) patient identification data;
- (ii) medical and dental history;
- (iii) medical history updates;
- (iv) clinical examination findings;
- (v) progress, diagnostic and consultation reports;
- (vi) each treatment prescribed pertaining to the patient;
- (vii) each treatment rendered pertaining to the patient;
- (viii) documented informed consent with respect to treatment prescribed and treatment rendered pertaining to the patient;
- (ix) each date that the patient is seen in the dental office;
- (x) all medications given or prescribed to the patient, including the amount, instructions, and date provided or prescribed;
- (xi) appropriate radiographs and models; and
- (xii) fees charged and collected.

(b) Where a patient has attended a registrant's facility for the purpose of receiving a treatment from any other dental professional, and such dental professional has recommended a dental examination by the dentist, the dentist shall ensure that such recommendation (and any refusal) shall be noted in the patient's records. No further action is required of the registrant once such notation has been made.

(c) All records shall be in an intelligible form, and shall be written, typed, or stored in electronic form with one or more backup copies.

(d) All registrants, professional corporations, and facilities shall acquire and maintain records in compliance with the Health Information Protection Act (HIPA), the Health Information Protection Regulations (HIPR), and the Personal Information Protection and Electronic Documents Act (PIPEDA).