



Please clearly summarize the incident resulting in hospitalization or mortality. Enclose copies of all records in your possession related to this patient. See the attached records check list for further detail. \*\* Please note if we are unable to read your report, processing will be delayed. \*\* A separate narrative and/or additional pages may be attached if preferred.

You may attach additional sheets if needed.

Send to:  
State Board of Dental Examiners  
333 Guadalupe, Tower 3, Suite 800  
Austin, TX 78701-3942

Fax: 512-463-7461

For information on filing a self-reporting email: [selfreports@tsbde.texas.gov](mailto:selfreports@tsbde.texas.gov)

\*\* DO NOT SUBMIT PROTECTED HEALTH INFORMATION VIA EMAIL \*\*

I certify that the above information is true and correct.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

# Texas State Board of Dental Examiners

## Checklist of REQUIRED Documents

**ALL** patient records related to **ANY** treatment rendered to your patient **MUST** be submitted to the Board, including (but not limited to) the following items. Please indicate the items included with your response and return this form to the State Board of Dental Examiners with the records.

**\*FOR ANY ITEMS MARKED "NO" BELOW, INCLUDE AN EXPLANATION ON THE REVERSE SIDE AS TO WHY ITEM IS NOT INCLUDED IN THE PATIENT CHART.**

Document / Record	Included?	
	Yes	No*
1. PATIENT INFORMATION SHEET (Name, address, contact information.)	<input type="checkbox"/>	<input type="checkbox"/>
2. MEDICAL HISTORY SHEET (Initial and all updated information.)	<input type="checkbox"/>	<input type="checkbox"/>
3. TREATMENT PLAN (including all alternate treatment plans.)	<input type="checkbox"/>	<input type="checkbox"/>
4. SIGNED CONSENT FORMS (for all treatment rendered - both general and treatment specific consent forms.)	<input type="checkbox"/>	<input type="checkbox"/>
5. PROGRESS/TREATMENT NOTES (including electronic or hand written notes detailing diagnosis and treatment rendered, medicines administered or prescribed, labels, sticky notes or other notations.)	<input type="checkbox"/>	<input type="checkbox"/>
6. RADIOGRAPHS (must be <b>DIAGNOSTIC QUALITY</b> duplicates. Digital radiographs <b>MUST</b> be submitted on photo quality paper if printed, or submitted on digital media such as CD/DVD. No photocopies. Each radiograph must indicate date taken.)	<input type="checkbox"/>	<input type="checkbox"/>
7. PATIENT ACCOUNT HISTORY - LEDGER / BILLING (Print out of all the patient's account history including billing history, insurance documents, EOB, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
8. PERIODONTAL AND RESTORATION CHARTING	<input type="checkbox"/>	<input type="checkbox"/>
9. DIAGNOSTIC IMAGES AND/OR PHOTOGRAPHS (Photos must include date taken.)	<input type="checkbox"/>	<input type="checkbox"/>
10. MODELS, CASTS, OR DRAWINGS - Initial and Final (Mandatory for ortho cases. Images of models may be used as long as they are of diagnostic quality and include a maxillary and mandibular occlusal view, left and right lateral views as, well as an anterior view.)	<input type="checkbox"/>	<input type="checkbox"/>
11. LAB PRESCRIPTIONS	<input type="checkbox"/>	<input type="checkbox"/>
12. DRUG PRESCRIPTIONS	<input type="checkbox"/>	<input type="checkbox"/>
13. REFERRAL FORMS / LETTERS	<input type="checkbox"/>	<input type="checkbox"/>
14. PATIENT CORRESPONDENCE	<input type="checkbox"/>	<input type="checkbox"/>
15. BUSINESS RECORDS AFFIDAVIT (Supplied by the Board of Dental Examiners. <b>MUST</b> be completed and notarized by the Custodian of Records or treating dentist.)	<input type="checkbox"/>	<input type="checkbox"/>

Any documents using color-coding type or labels must be submitted in color. A typed transcript must accompany any illegible handwritten notes. All photocopied documents must be provided in a clearly legible and complete form.

Failure to submit **any** record, document, image or electronic record of any kind, including the notarized Business Records Affidavit may be considered non-compliance. The Board may not consider any documents submitted at a later date. **It is the responsibility of the Respondent/licensee to review all records submitted to the Board on their behalf to assure they are complete and accurate.** Administrative penalties may be assessed for non-compliance with this request.

**\*\* DO NOT SUBMIT ORIGINAL DOCUMENTS UNLESS REQUESTED BY THE BOARD. UNSOLICITED ORIGINALS MAY NOT BE RETURNED.\*\***

Form completed by: \_\_\_\_\_ Date: \_\_\_\_\_





## Texas State Board of Dental Examiners

333 Guadalupe, Tower 3, Suite 800

Austin, Texas 78701-3942

Main Phone: (512) 463-6400 & Fax: (512) 463-7452

Enforcement Division Complaints Fax: (512) 463-7461

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### **Business Records Affidavit**

#### **IMPORTANT INSTRUCTIONS**

#### **SAMPLE FORM ON BACK**

**This affidavit should be completed for all patient records requested by the Board. Failure to execute this affidavit by a licensee is considered non-compliance with TSBDE Rule 108.8(f).** It must be executed before a Notary Public or other official authorized to administer oaths and attached to applicable business records. **Please fill out the form in its entirety. You must print, sign it, and mail or fax the form along with the applicable records to the address above.**

#### **INSTRUCTIONS FOR SUBMITTING RECORDS TO THE BOARD**

In order to comply with a request for records by the SBDE, a licensee must submit unaltered copies of **ALL** records maintained on this patient. Copies of records are preferred; **\*\* DO NOT SUBMIT ORIGINAL DOCUMENTS UNLESS REQUESTED BY THE BOARD. UNSOLICITED ORIGINALS MAY NOT BE RETURNED.\*\*** **ALL** records including, but not limited to the items in the attached checklist. Indicate on the checklist if your response includes the listed items and return the checklist with the Business Records Affidavit.

Failure to submit ***any*** record, document, image or electronic record of any kind, including the notarized Business Records Affidavit may be considered non-compliance. The TSBDE may not consider any documents submitted at a later date. **It is the responsibility of the Respondent/licensee to review all records submitted to the Board on their behalf to assure they are complete and accurate.** Administrative penalties may be assessed for non-compliance with this request.

# Business Records Affidavit



## Texas State Board of Dental Examiners

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Austin, Texas 78701-3942  
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## SAMPLE FORM

PLEASE USE THE FOLLOWING FORMAT TO COMPLETE THE ATTACHED FORM.

Before me, the undersigned authority, personally appeared CUSTODIAN OF RECORDS/CLERK'S NAME who being by me duly sworn, deposed as follows:

My name is CUSTODIAN OF RECORDS/ CLERK'S NAME, I am over twenty-one years of age, of sound mind, capable of making this affidavit, and personally acquainted with the facts herein stated:

I am the custodian of the records of CLINIC OR DENTIST NAME. Attached hereto are ## sheets of records from CLINIC OR DENTIST NAME. These said ## sheets of records are kept by CLINIC OR DENTIST NAME in the regular course of business, and it was the regular course of business in the CLINIC OR DENTIST NAME for an employee, representative, or dentist of the CLINIC OR OFFICE NAME with personal knowledge of the act, event or condition recorded to make the memorandum or record or to transmit information thereof to be included in such memorandum or record; and the memorandum or record was made at or near the time of the act, event or condition recorded or reasonably soon thereafter. The records attached hereto are exact duplicates of the original and it is a rule of the CLINIC OR DENTIST NAME to not permit the originals to leave the facility.

CUSTODIAN OF RECORDS/ CLERK'S SIGNATURE

AFFIANT'S SIGNATURE

SWORN TO AND SUBSCRIBED before me on the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

Notary Public, State of Texas \_\_\_\_\_

<SEAL>

Notary Public Printed Name \_\_\_\_\_

My Commission Expires \_\_\_\_\_

# Business Records Affidavit



## Texas State Board of Dental Examiners

333 Guadalupe, Tower 3, Suite 800

Austin, Texas 78701-3942

Main Phone: (512) 463-6400 & Fax: (512) 463-7452

Enforcement Division Complaints Fax: (512) 463-7461

Regarding Patient \_\_\_\_\_ Texas dental license number: \_\_\_\_\_

Before me, the undersigned, personally appeared \_\_\_\_\_ who being by me duly sworn, deposed as follows:

My name is \_\_\_\_\_, I am over twenty-one years of age, of sound mind, capable of making this affidavit, and personally acquainted with the facts herein stated:

I am the custodian of records of \_\_\_\_\_. Attached hereto are \_\_\_\_\_ sheets of records from \_\_\_\_\_. These said \_\_\_\_\_ sheets of records are kept by \_\_\_\_\_ in the regular course of business, and it was the regular course of business in the \_\_\_\_\_ for an employee, representative, or dentist of the \_\_\_\_\_ with personal knowledge of the act, event or condition recorded to make the memorandum or record or to transmit information thereof to be included in such memorandum or record; and the memorandum or record was made at or near the time of the act, event or condition recorded, or reasonably soon thereafter. The records attached hereto are exact duplicates of the originals and it is a rule of the \_\_\_\_\_ to not permit the originals to leave the facility.

\_\_\_\_\_  
AFFIANT'S SIGNATURE

SWORN TO AND SUBSCRIBED before me on the \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_

<Seal>

Notary Public, State of Texas \_\_\_\_\_

Notary Public Printed Name \_\_\_\_\_

My Commission Expires \_\_\_\_\_