



DEPARTMENT OF THE NAVY
BUREAU OF MEDICINE AND SURGERY
2300 E STREET NW
WASHINGTON DC 20372-5300

Canc frp: Jan 2000
IN REPLY REFER TO
BUMEDNOTE 6150
BUMED-631
29 Jan 99

BUMED NOTICE 6150

From: Chief, Bureau of Medicine and Surgery
To: Ships and Stations Having Dental Personnel

Subj: NAVY DENTAL TREATMENT RECORD

Ref: (a) SECNAVINST 5212.5C
(b) SECNAVINST 5211.5D
(c) SECNAVINST 5213.10D (NOTAL)
(d) BUMED-06 ltr 6600 ser.631/0014 of 31 Jan 97
(e) Manual of the Medical Department, chapter 6
(f) NAVMEDCOMINST 6320.3B

Encl: (1) Dental Treatment Record Manual

1. Purpose. To prescribe administrative procedures for Navy Dental Treatment Records.

2. Background. NAVMEDCOMINST 6150.1, the Bureau of Medicine and Surgery (BUMED) directive governing the administration of both medical and dental treatment records, has been canceled. The administration of medical records is now governed by the Manual of the Medical Department (MANMED), chapter 16. This notice governs the administration of dental records until MANMED, chapter 6 is modified in December 1999.

3. Program Guidance. Reference (a) authorizes the Medical Department to use records in the performance of dental care and prescribes retention and disposal standards for those records. Reference (b) prescribes policies, conditions, and procedures that govern collecting personal information; and safeguarding, maintaining, using, accessing, amending, and disseminating personal information kept by the Department of the Navy (DON) in its systems of records. Reference (b) delegates the Chief, BUMED the authority to deny requests for notification, access, and amendment, made under the instruction, of dental records.

4. Responsibilities

a. Bureau of Medicine and Surgery. The Dental Standards Branch, MED-631, is responsible for the administration of the Navy's Dental Record Program. This includes:

29 Jan 99

(1) Developing policies and program guidance concerning the construction, management, maintenance, transfer, and retirement procedures for Navy dental records.

(2) Serving as technical advisor on dental records management to all DON facilities maintaining dental records.

(3) Administering the Privacy Act of 1974 as applicable to Navy dental records per reference (b).

b. Dental Treatment Facilities (DTFs). Commanding officers of dental commands, branch clinic directors or officers in charge of DTFs, and commanding officers of units with dental departments are responsible for implementing and complying with the requirements of this notice. This responsibility includes:

(1) Designating a member for each naval dental command as the dental record administrator.

(2) Holding members of their command accountable for following the regulations pertaining to dental records and forms as prescribed in this notice.

(3) Assessing compliance with this notice periodically (at least annually), documenting assessment findings, and taking corrective action to ensure the requirements are met.

5. Custody of Treatment Records. Dental treatment records, NAVMED 6150/21-30 and their contents, are the property of the Federal Government and must be retained in a DTF. Per appendix A to reference (a), the practice of patients maintaining custody of their own dental records is prohibited. Dental records must be protected and preserved as they are of long term, continuing interest to the patient and the Federal Government. Dental records must be readily available not only for future treatment, but also for resolving claims and other medical-legal questions. DTFs must maintain strict accountability for the dental records in their custody. If the use of a chargeout system to other treatment facilities providing care is not feasible, the strict use of the Health Record Receipt (pink card), NAVMED 6150/7, becomes increasingly important.

6. Restrictions. The following restrictions are prescribed to establish a standard dental record jacket and to ensure ready interchangeability between DTFs:

a. NAVMED 6150/21-30 must not be permanently altered by stamp, tape, or other means, without prior approval of BUMED, except as authorized by this notice.

b. Army, Air Force, and Coast Guard dental record jackets must not be used as a substitute for NAVMED 6150/21-30.

c. Use of locally developed dental record jackets, instead of NAVMED 6150/21-30, is not authorized. Local forms must not be used instead of standard forms (SFs) or other higher echelon health care treatment forms per references (c) and (d).

7. Action. Using enclosure (1), addressees must comply with the procedures and policies in this notice and associated guidance in reference (e).

8. Point of Contact. The Standards Branch, MED-631, is the point of contact for all inquiries and recommendations concerning the dental record jacket, its associated forms, and all pertaining policies.

9. Forms

a. The following forms are available per CD-ROM NAVSUP PUB 600 (NLL):

(1) NAVMED 6150/21-30, Treatment Record

<u>Form Number</u>	<u>Stock Number</u>
NAVMED 6150/21 (11-96)	0105-LF-113-8700
NAVMED 6150/22 (11-96)	0105-LF-113-8800
NAVMED 6150/23 (11-96)	0105-LF-113-9000
NAVMED 6150/24 (11-96)	0105-LF-113-9100
NAVMED 6150/25 (11-96)	0105-LF-113-9200
NAVMED 6150/26 (11-96)	0105-LF-113-9300
NAVMED 6150/27 (11-96)	0105-LF-113-9400
NAVMED 6150/28 (11-96)	0105-LF-113-9500
NAVMED 6150/29 (11-96)	0105-LF-113-9600
NAVMED 6150/30 (11-96)	0105-LF-113-9700

(2) NAVMED 6150/7 (2-74), Health Record Receipt, S/N 0105-LF-209-5071; NAVMED 6600/3 (1-92), Dental Health Questionnaire, S/N 0105-LF-013-7700; NAVMED 6600/12 (6-93), Reserve Dental Assessment and Certification, S/N 0105-LF-016-4400; DD 2005 (2-76), Health Care Records, Privacy Act Statement, S/N 0102-LF-002-0051; OPNAV 5510/415 (3-94), Record Identifier

BUMEDNOTE 6150
29 Jan 99

for Personnel Reliability Program, S/N 0107-LF-017-6800; SF 603 (10-75), Health Record-Dental, S/N 0105-LF-011-9300; and SF 603A (10-75), Health Record-Dental Continuation, S/N 0105-LF-011-9400.

b. SF 502 (7-91), Narrative Summary, NSN 7540-00-634-4114; SF 509 (7-91), Progress Notes (medical record), NSN 7540-00-634-4122; SF 513 (9-77), Consultation Sheet, NSN 6540-00-634-4127; SF 515 (9-77), Tissue Examination, NSN 7540-00-634-4155; SF 517 (10-75), Anesthesia, NSN 7540-00-634-4157; SF 522 (12-94), Request for Administration of Anesthesia and for Performance of Operations and Other Procedures, NSN 7540-00-634-4165; and SF 600 (5-84), Chronological Record of Medical Care, NSN 7540-00-634-4176 are available from the Federal Supply System through normal supply procurement procedures.

c. Trial Forms, to be used per reference (d), Dental Examination EZ603; Dental Treatment EZ603A; and Current Status are available from BUMED (MED-631).

10. Cancellation Contingency. Canceled upon incorporation into reference (e).



J. K. JOHNSON
Assistant Chief for Dentistry

Available at:
<http://support1.med.navy.mil/bumed/instruct/external/external.htm>

BUMEDNOTE 6150
29 Jan 99

DENTAL TREATMENT RECORD MANUAL

**Bureau of Medicine and Surgery
Standards Branch (MED-631)
Washington, DC 20372-5300**

December 1998

Enclosure (1)

CONTENTS

<u>Title</u>	<u>Paragraph</u>	<u>Page</u>
Preparation of the Dental Record Jacket	1	1
General	1a	1
Recording Identifying Data	1b	1
Social Security Number (SSN)	1b(1)	1
Preprinted Digit	1b(1)(a) ...	1
Jacket Selection and Entries	1b(1)(b) ...	1
Patients without SSNs	1b(1)(c) ...	2
Family Member Prefix (FMP) Code	1b(2)	2
Data on Front Cover of the Dental Record Jacket	1b(3)	3
Name	1b(3)(a) ...	3
Alert	1b(3)(b) ...	3
Pencil Entries	1b(3)(c) ...	3
Record Category	1b(3)(d) ...	3
Service and Status	1b(3)(e) ...	3
Annual Verification	1b(3)(f) ...	4
Data on Inside Front Cover of the Dental Record Jacket	1b(4)	4
Arrival Date	1b(4)(a) ...	4
Projected Rotation Date	1b(4)(b) ...	4
Local Home Address (or Mailing Address)....	1b(4)(c) ...	4
Local Home Telephone Number	1b(4)(d) ...	4
Command UIC (Optional).....	1b(4)(e) ...	4
Work Telephone	1b(4)(f) ...	4
Work Telephone (Family Members).....	1b(4)(g) ...	4
Privacy Act Statement	1b(5)	5
Disclosure Accounting Record.....	1b(6)	5
Forensic Examination	1b(7)	5
Remarks	1b(7)(c) ...	5
Soft Tissue Remarks	1b(7)(d) ...	5
Occlusion	1b(7)(e) ...	5
Hard Tissue Remarks	1b(7)(f) ...	6
Doctors Signature	1b(7)(g) ...	6
Record Retirement Tape	1c	6
Record Category Tape	1d	7
Dental Classification	1e	7
Contents of the Dental Record	2	7
General	2a	7
Identification of Forms	2a(1)	7
Arrangement of Forms	2a(2)	8
Inside Front Cover of Dental Record Jacket	2b	8
Front of Dental Record Jacket Center Page.....	2c	8

<u>Title</u>	<u>Paragraph</u>	<u>Page</u>
Contents of the Dental Record (Continued)		
Back of Dental Record Jacket Center Page	2d	8
Inside Back Cover of Dental Record Jacket	2e	8
Additional Forms	2f	9
Maintenance of the Dental Record	3	9
Terminal Digit-SSN Filing	3a	9
Internal Chargeout Control	3b	9
Chargeout Form	3b(1)	9
Chargeout Guide	3b(2)	10
Records Review	3c	10
Inactive Records	3c(1)	10
Verification of Records	3c(2)	11
Illegible or Contaminated Dental Records	3c(3)	11
Transfer of the Dental Record	4	11
Temporary Transfers, Active Duty	4a	11
Handcarrying Personal Dental Record	4a(1)	11
Handcarrying Family Member's Dental Record ..	4a(2)	12
Copies of Dental Records	4a(3)	12
Permanent Transfers to Ships or Stations, Active Duty	4b	12
Family Member Transfers	4c	13
Temporary Dental Records	5	13
Custody of Temporary Dental Record	5a	13
Construction of Temporary Dental Record	5b	13
Disposition of Temporary Dental Record	5c	14
Loose Treatment Forms	5d	14
Retirement of the Dental Record	6	14
Release of Information	7	14
Sample of Front Cover of Dental Record	Figure 1 ...	15

DENTAL RECORD MANUAL

1. Preparation of the Dental Record Jacket (NAVMED 6150/21-30)

a. General. A dental record shall be established for every individual receiving dental care in a Navy DTF, except when dental care is limited to participation in a group preventive dentistry program. Categories of eligible beneficiaries are listed in reference (f). Dental records prepared for eligible beneficiaries shall be placed in the custody of the DTF responsible for the individual's dental treatment. The following procedures for establishing dental records apply to all eligible beneficiaries receiving outpatient dental care. Figure 1 is a sample of the front cover of a dental record jacket (NAVMED 6150/21-30). Refer to figure 1 on page 15 of this enclosure as a guide for preparing dental records using the following specific instructions.

b. Recording Identifying Data. Use an indelible black felt-tip pen, black ink, or pencil, as indicated, to record all patient identifying data.

(1) Social Security Number (SSN)

(a) Preprinted Digit. The second to last digit of the SSN is preprinted on the dental record jacket (see figure 1). The preprinted digit also matches the last digit of the form number (e.g., the preprinted digit on NAVMED 6150/26 is a 6). The color of the treatment record jacket corresponds to the preprinted digit as follows:

<u>Preprinted Digit</u>	<u>Jacket Color</u>
1	Green
2	Yellow
3	Gray
4	Tan
5	Blue
6	White
7	Almond
8	Pink
9	Red
0	Orange

(b) Jacket Selection and Entries. Select a prenumbered NAVMED 6150/21-30 jacket matching the second to the last number of the sponsor's SSN. Enter the first seven digits

and the ninth digit of the SSN. Using a 1-inch long, 1/2-inch wide strip of black tape, tape over the number that corresponds to the last digit of the SSN in each of the two number scales (see figure 1). The tape must completely blacken out the number and extend around the edge of the jacket to the back.

(c) Patients without SSNs. For patients who do not have an SSN (e.g., foreign personnel and their family members), create a "substitute" SSN by coding the first three digits 800 and the last six digits as the month, day, and year of the patient's birth (i.e., MM-DD-YY). As an example, for a patient who was born on July 10, 1945, assign SSN 800-07-1045. For subsequent patients with the same birth date, assign the first three digits sequentially starting with 801. Select a prenumbered NAVMED 6150/21-30 jacket matching the second to the last number of the patient's "substitute" SSN and complete the jacket as prescribed in paragraphs 1b(1)(b) through 1e.

(2) Family Member Prefix (FMP) Code. Enter the patient's FMP code in the two diamonds preceding the SSN (see figure 1) per the following table:

<u>Relationship to Sponsor</u>	<u>FMP Code</u>
Sponsor's oldest child (include stepchildren)	01
Sponsor's next oldest child	02
Sponsor's third oldest child, etc.	03, 04, etc.
Sponsor (active duty, retired, and Reserve uniformed services personnel of Army, Navy, Air Force, Marine Corps, Coast Guard, Public Health Service, and National Oceanic and Atmospheric Administration)	20
<u>1/</u> Sponsor's current spouse	30
<u>1/</u> Sponsor's eligible former spouses	31 - 39
Sponsor's family member mother/stepmother	40 - 44
Sponsor's family member father/stepfather	45 - 49
Sponsor's family member mother-in-law	50 - 54

<u>Relationship to Sponsor (continued)</u>	<u>FMP Code</u>
Sponsor's family member father-in-law	55 - 59
Other authorized sponsor's family members	60 - 69
Beneficiaries authorized by statute (SECNAV designees, etc.)	90
Nonbeneficiary emergencies	98
All other authorized personnel (foreign nationals, etc.)	99

1/ The spouse of a deceased sponsor will continue to use the sponsor's SSN. If the sponsor had no SSN, use the sponsor's military serial or service number preceded by leading zeros to complete a 9-digit number.

(3) Data on Front Cover of the Dental Record Jacket. All entries on the front cover, except "Pencil Entries" are made with black felt tip pen.

(a) Name. Enter the patient's name in the upper right corner in the following sequence: last, first, middle. Indicate no middle name by the abbreviation "NMN." The name shall be written on the line provided. For all retired flag and general officers (i.e., O-7 and above) enter the phrase "FLAG OFFICER" or "GENERAL OFFICER," as appropriate, in the lower portion of the patient's identification box.

(b) Alert. Immediately below the instruction box, indicate in the alert box whether the patient has sensitivities or allergies by entering an "X" in the appropriate boxes. (If none, leave blank.)

(c) Pencil Entries. Enter the patient's command and grade or rate for active duty. For all others enter their preferred form of address.

(d) Record Category. Below the pencil entries box, indicate the record category by entering an "X" in the box marked "Dental Treatment Record."

(e) Service and Status. Immediately below the record category box, indicate the sponsor's branch of military service

BUMEDNOTE 6150
29 Jan 99

by entering an "X" in the appropriate box. If the sponsor is not an active duty Navy or Marine Corps member, enter an "X" in the "Other" box and write the Service and rate or grade on the line provided. Check remaining boxes as applicable with the additional comments as follows:

1. Retired. Check box if applicable and indicate service and rate on line provided.

2. Family Member. Check box if applicable and indicate relationship to sponsor.

3. Family Member Insurance. Check "Yes" or "No" regarding dental insurance the family member may have. (e.g., United Concordia Companies, Inc. (UCCI), DELTA, HUMANA, etc.)

4. Blood Type. Indicate blood type of patient.

(f) Annual Verification. Leave blank. This block shall not be completed for dental records. See paragraph 3c(2).

(4) Data on Inside Front Cover of the Dental Record Jacket. The format printed on the inside of the jacket front cover shall be completed in pencil as follows. This information shall be entered at the time of record check-in (receipt) and shall be kept current at all times by erasing previous, outdated entries.

(a) Arrival Date. Enter date sponsor arrived at present duty station, if applicable.

(b) Projected Rotation Date. Enter date sponsor is projected to rotate to a new duty station, if known and if applicable.

(c) Local Home Address (or Mailing Address). Self-explanatory.

(d) Local Home Telephone Number. Self-explanatory.

(e) Command UIC (Optional). Self explanatory, if applicable.

(f) Work Telephone. Self-explanatory, if applicable.

(g) If a Family Member, Sponsor's Work Telephone Number. Self-explanatory, if applicable.

(5) Imprint of DD 2005, Privacy Act Statement (front of center page). Signed in black ink by the patient, parent, or guardian, if the patient is a minor.

(6) Disclosure Accounting Record (back of center page). Fill out as needed.

(7) Forensic Examination (inside back cover of dental jacket).

(a) This section is completed in black ink, using the symbols and notations found in MANMED chapter 6, section XV. Note: This section need not be completed if the patient has an intact SF 603 currently in their record.

(b) The teeth are separated on the "odontogram" to facilitate illustrating supernumerary teeth, mixed dentition, and interproximal restorations.

1. If a restoration exists interproximally with no occlusal component, use the space to draw the restoration.

2. When indicating fixed partial dentures, ignore the spaces. Draw the prosthesis and indicate the materials and teeth involved in the remarks section.

(c) Remarks. Use this section to indicate restorative materials and differentiate between sealants, composites, and temporaries.

(d) Soft Tissue Remarks. This is a partial list of the more common non-pathologic findings to facilitate charting. For each condition, indicate approximate size or extent and location. Leave blank, if normal.

(e) Occlusion

1. Angle's Class: I, II, or III. Each side may be different.

2. Overjet and Overbite: Indicate millimeters; leave blank, if normal.

3. Crossbite: Indicate teeth involved.

4. Remarks: Use for other occlusion-related comments.

(f) Hard Tissue Remarks. This is a partial list of the more common nonpathologic findings to facilitate charting. Leave blank, if normal.

1. Intrinsic Staining: Indicate teeth involved. Check tetracycline, if appropriate.

2. Tori: Indicate location and approximate size.

3. Rotated Teeth: Indicate teeth involved and approximate number of degrees to the nearest 45 degrees.

4. Malposed teeth: Indicate teeth involved and whether facio- or linguo- version.

5. Other: Use for other hard tissue related comments.

(g) Doctor's Name Stamp, Signature, Patient Identification Blocks. Complete as indicated.

c. Record Retirement Tape

(1) For records of nonmilitary patients a tentative record retirement date (retirement year) shall be indicated on all dental records by attaching a colored tape in the box marked "RET YR TAPE" on the right margin of the jacket back cover. Use 1/2-inch wide tape in strips 1-inch long. Attach the tape in the space provided and extend the tape around the edge of the jacket to the back. Mark jackets with the following color sequence, which is repeated at 6-year intervals:

<u>Date of Last Treatment (Calendar Year)</u>	<u>Color Tape for Jacket</u>
1995, 2001, 2007	Green
1996, 2002, 2008	Red
1997, 2003, 2009	Blue
1998, 2004, 2010	Black
1999, 2005, 2011	Yellow
2000, 2006, 2012	White
2001, 2007, 2013	Green

(2) A record will be retired January 1 of the calendar year (CY) following a 24-month period of no patient examination or treatment. For example, patients last seen during CY 1995 will have jackets taped green to show the tentative record

retirement date of 1 January 1998. The retirement year tape color sequence shall be updated as records are pulled from the file for care and treatment. When patients are treated during CY 1996, the record retirement date shall be changed by attaching red tape over the green indicating a new tentative retirement date of 1 January 1999.

d. Record Category Tape. Immediately below the retirement year tape box is a similar box which shall be used to indicate the record category. Use 1/2-inch wide, bright-colored tape in strips approximately 1-inch long. Attach the tape in the space provided and extend the tape around the edge of the jacket to the back. All dental records shall be identified with colored tape in the "RECORD CATEGORY TAPE" box, according to the following table:

<u>Record Category</u>	<u>Color Tape</u>
Active duty military (This includes Reserves on active duty over 30 days)	Blue
Reserve military, not on active duty	Red
Family member	Yellow
Retired	Green
All other	Black

e. Dental Classification Tape. Color coded dental classification tapes are no longer used.

2. Contents of the Dental Record

a. General. Each dental record shall consist of a NAVMED 6150/21-30, Treatment Record jacket, containing only the health care treatment forms prescribed below. Approved exceptions are specified in paragraph 2f.

(1) Identification of Forms. It is imperative that all forms documenting patient care contain adequate data to identify the patient and permit filing of the forms in the dental record. All data elements in the dental examination and treatment forms shall be completely filled out. All other forms filed in the dental record shall, at a minimum, contain the following data in the identification block:

(a) Patient's FMP and sponsor's SSN. See paragraph 1b(2).

(b) Patient's name (last, first, middle initial).

(c) Sponsor's branch of Service (e.g., Army, Navy, or Air Force) and patient's status (e.g., family member or retired).

(2) Arrangement of Forms. Prescribed forms shall be filed in the dental record in the following order. The forms shall be arranged in top to bottom sequence; like numbered forms shall be grouped together with the most recent form placed on top of each previous form, unless otherwise specified below.

b. Inside Front Cover of Dental Record Jacket

(1) Unmounted radiographs in envelopes.

(2) Sequential bitewing radiograph mounts.

(3) Panorgraphic or fullmouth radiographs.

c. Front of Dental Record Jacket Center Page

NAVMED 6600/3, Dental Health Questionnaire.

d. Back of Dental Record Jacket Center Page

Trial Dental Examination Forms, EZ603, (Treatment Plan side up) in reverse chronological order.

e. Inside Back Cover of Dental Record Jacket

(1) Record Identifier for Personnel Reliability Program OPNAV 5510/415 (if applicable).

(2) Trial Current Status Form.

(3) Reserve Dental Assessment and Certification Form, NAVMED 6600/12 (if applicable).

(4) Most Current Trial Dental Treatment Form, EZ603A.

(5) Previous Dental Treatment Forms (EZ603As, SF 603s, and SF 603As) in reverse chronological order.

(6) Consultation Sheet, SF 513 (when related to dental treatment).

(7) Narrative Summary, SF 502 (when related to dental treatment).

(8) Doctor's Progress Notes, SF 509 (when related to dental treatment).

(9) Tissue Examination, SF 515 (if required).

(10) Request for the Administration of Anesthesia and for Performance of Operations and Other Procedures, SF 522 (if required).

f. Additional Forms. Under the following conditions, additional dental treatment forms are approved for inclusion in the dental record.

(1) Other health care treatment forms (e.g., Veterans Affairs (VA), Office of Personnel Management (OPM), Compensation Act (CA), standard forms (SF), optional forms (OF), and civilian practitioner forms) not prescribed for use may be incorporated in the dental record when considered necessary to document care and treatment. The forms shall be filed at the bottom of the right side of the dental record, like numbered forms grouped together with the most recent form placed on top of each previous form.

(2) Pertinent health care information, necessary to document treatment, but not available on authorized forms as listed above, may be filed in the treatment record. When feasible, attach the form to the appropriate approved form (e.g., attach summaries of reports from civilian practitioners to SF 603) in the proper sequential order as specified in paragraphs 2b and 2c. When mounting is not feasible, file the original form in the same position as the equivalent authorized form.

3. Maintenance of the Dental Record

a. Terminal Digit-SSN Filing. Follow the same procedures for establishing a terminal digit-SSN file specified in MANMED, chapter 16, article 16-18.

b. Internal Chargeout Control

(1) Chargeout Form. NAVMED 6150/7, Health Record Receipt, shall be used for chargeout control of dental records.

BUMEDNOTE 6150
29 Jan 99

A receipt shall be prepared for each dental record established and shall be filed in the record. The following shall be recorded on each health record receipt when the treatment record is received.

(a) Patient's name (last, first, middle initial).

(b) Sponsor's grade or rate.

(c) Patient's FMP code and sponsor's SSN.

(d) Ship or station to which sponsor is assigned.

Use home address for retired personnel and their family members and for those family members of active duty personnel when the sponsor is assigned duty out of the area. The completed charge-out form shall be retained in the terminal digit file until the record is returned. A color coding system may be used in conjunction with the chargeout form to denote the day or week the record is charged out from the file. See paragraph 3b(2) below. Records charged out from the file shall be returned as soon as possible after the patient's visit, but not more than 5 working days. DTFs shall develop local procedures for the recovery of delinquent treatment records.

(2) Chargeout Guide. If open shelf filing is used for dental records, a chargeout guide may be used in conjunction with the chargeout form. A chargeout guide is a plastic "folder" with a "pocket." The chargeout form should be placed in the pocket and the chargeout guide placed in the file in place of the patient's record until the record is returned. Chargeout guides are available in various colors from commercial sources. By using different colored chargeout guides to denote the day or week a record is charged out from the file, a quick reference is provided.

c. Records Review

(1) Inactive Records. Dental records become eligible for retirement due to inactivity. However, allowance must be made for longer sponsor tours of duty, extensions of the sponsor's projected rotation date, and back-to-back tours of duty in the same area. Problems arise as a result of premature retirement of a dental record of a patient who has not requested treatment during the previous 2-year period. Subsequent treatment will be impeded and a lengthy administrative action will be required to retrieve the patient's record. Accordingly, DTFs shall develop local procedures to ensure, to the maximum extent possible,

dental records are not retired without an attempt to verify the sponsor's duty status and location. Records will be retired following reference (e), article 16-20.

(2) Verification of Records. Dental records shall be verified for accuracy when transferred, retired, or at other times as the director of the DTF directs. At these times, records shall be reviewed for proper identification, placement of forms, and completion of the record jacket according to the requirements of this notice. Specifics of record verification:

(a) Verify the record with the patient present, if possible.

(b) Cross-check the military patient's name or sponsor's name against a current roster of the patient's or sponsor's last known unit. This is essential.

(c) Verify Privacy Act Statement has been signed.

(d) Verify pencil entries are complete and accurate.

(e) Verify treatment plan is current (i.e., the treatment plan is not over 12 months old).

(f) Appoint the patient for treatment if the patient is dental class 3. Appoint the patient for a T-2 examination if the patient is dental class 1 or 2 and 12 months or more have elapsed since the last T-2 examination.

(3) Illegible or Contaminated Dental Records. Dental records which are illegible or contaminated will be processed according to reference (e), article 16-19.

4. Transfer of the Dental Record. The following procedures are designed to protect against loss or misfiling of the dental record during transfer between treatment facilities without jeopardizing the interests of the individual or the Federal Government.

a. Temporary Transfers, Active Duty. When a dental record is transferred temporarily to another activity (e.g., for consultation or specialty treatment), follow the procedures in paragraph 3b to prepare and maintain chargeout cards or guides.

(1) Handcarrying Personal Dental Record. Patients frequently handcarry their dental records when they have an

BUMEDNOTE 6150
29 Jan 99

appointment external to the record keeping DTF. If resources and time permit, however, the record should be delivered to the consulting provider with instructions to return it the same way. Do not jeopardize patient care or unnecessarily inconvenience the patient.

(2) Handcarrying Family Member's Dental Record. If an adult patient's dental record is handcarried by someone other than the patient (spouse or an adult family member), release of the record must be authorized by the patient. Dental records of minor children may be released to the parent, sponsor, spouse, other adult family member, or the child's legal guardian. In divorce cases, a child's dental record may only be released to the parent who has been awarded custody of the child by a court order.

(3) Copies of Dental Records. Excerpts from or copies of dental records for the patient may be approved by the treating dentist or DTF director using the regulations in paragraphs 4a(1) and 4a(2).

b. Permanent Transfers to Ships or Stations, Active Duty.
At the time of patient checkout from the DTF:

(1) If no dental record exists, construct a new dental record following this notice and perform a T-2 dental examination per reference (e), articles 6-99 through 6-101.

(2) Verify dental record per paragraph 3c(2).

(3) Ensure patient has been processed for transfer.

(4) Complete dental record chargeout per paragraph 3b.

(5) Allow active duty members to handcarry their dental record, unless the DTF or member's command determines it is not in the Navy's or member's interest to do so. If the dental record is not to be handcarried, forward it via certified mail or place the dental record in the custody of authorized personnel.

(6) Foreign Service Expeditions. When a member is to participate in a foreign service expedition and there is a possibility of loss or seizure of the record, it is advisable to make copies of the pertinent parts of the dental record and retain in a safe place. This provides an identification source should there be a fatality and the original record is lost or

destroyed. The copy should be placed in a dental record jacket and be clearly marked as a "DUPLICATE RECORD." See reference (e), article 16-19.

(7) Independent Duty. If a member is ordered to independent duty where there is no DTF, the dental record should be placed with the member's service record.

(8) When practicable, the dental record should accompany the member being transported by the Military Sealift Command.

(9) In instances of unauthorized absence before departure of a ship or other unit on an extended assignment, deliver the dental record to the member's commanding officer to accompany the member's service record.

c. Family Member Transfers. When a sponsor changes stations, he or she will generally be permitted to handcarry the dental records of minor and incompetent adult family members to the next DTF. The dental record of an adult family member can be released to that person only, unless that person authorizes in writing another individual to receive the record. If the member's command determines handcarrying the record is not in the best interest of the patient or the Navy, the DTF must forward the record via certified mail. See paragraph 4a(2).

5. Temporary Dental Records. In certain cases, a DTF may require the establishment of a temporary dental record, in addition to the patient's permanent dental record. Temporary records are required to ensure the timely availability of information that documents a current course of treatment for a patient being seen in the DTF. An example is a military member on temporary additional duty without his or her dental record who requires emergency dental treatment.

a. Custody of Temporary Dental Record. The temporary dental record is maintained by the DTF providing the current course of treatment. When the treatment is complete or when the patient returns to the location of the permanent dental record, the patient may handcarry the record, or the custodian of the temporary record may forward it, to the custodian of the permanent record.

b. Construction of Temporary Dental Record. The temporary dental record must, at a minimum, contain the following:

(1) Privacy Act Statement, DD 2005.

BUMEDNOTE 6150
29 Jan 99

(2) Dental Health Questionnaire, NAVMED 6600/3.

(3) Health Record--Dental Continuation, SF 603A.

If a dental record jacket (Treatment Record, NAVMED 6150/21-30) is not used, care must be taken to securely fasten any radiographs to the forms comprising the temporary dental record.

c. Disposition of Temporary Dental Record. As soon as possible, the temporary dental record must be merged with the permanent dental record including all forms except the Privacy Act Statement. There should be only one Privacy Act Statement in the permanent dental record. An entry must be made in the permanent dental record's most current dental treatment form that the merger has occurred.

d. Loose Treatment Forms. When loose treatment forms are discovered, every effort should be made to determine the present location of the dental record. If reasonable search efforts do not locate the dental record, retain loose treatment forms for a period of 1 year. Upon expiration of the retention period, destroy the forms locally according to paragraph 6 of the standard subject identification code 6150 in reference (a).

6. Retirement of the Dental Record. Dental records shall be verified and retired according to paragraph 3c. Records shall be retired to the National Personnel Records Center, Military Personnel Records, 9700 Page Boulevard, St. Louis, MO 63132, according to paragraph 5 of the standard subject identification code 6150 of reference (a). Eligible records shall be retired in numerical (terminal digit) order and shall be accompanied by corresponding locator cards, or other cross-reference media, in alphabetic order.

7. Release of Information. Information in the dental record is personal and is considered privileged. Accordingly, treatment records shall not be released to any person or organization in a manner that will compromise the interests of the individual or the Federal Government. All record disclosures shall be documented with entries in the Disclosure Accounting Record imprinted on the back of the center page of NAVMED 6150/21-30. References (a) and (e) prescribe procedures for the release of information from health care treatment records.

The diagram shows a form titled "U.S. Navy Medical Outpatient and Dental Treatment Record". At the top is a Social Security Number (SSN) field with digits 0-9 and a diamond symbol. Below this is a "PENCIL ENTRIES" section with fields for "COMMAND" and "TITLE". To the right is a "PATIENT'S FULL NAME" field with sub-fields for "LAST", "FIRST", and "MIDDLE". Below the name field is a "MILITARY" section with checkboxes for "Active duty family grade or rate", "Retired", "Family Member", "Civilian", "Personal Reliability Program", "Blood Type", "Flight Status", "Food Handler", "Radiation Exposure", "Asbestos Surveillance", and "Medical Condition". There are also checkboxes for "Outpatient Treatment Record" and "Dental Treatment Record". A "Military" section includes checkboxes for "Navy", "Marine Corps", and "Other". An "Alert" box contains checkboxes for "Allergies" and "Sensitivities". On the right side, there is a vertical list of years from 1996 to 2014. A "Warning" box at the bottom states: "Warning: Property of US Government. Possession by individual without proper authorization is prohibited. Removal of this record or its contents from the treatment facility is prohibited unless authorized by appropriate authority. Postmaster, forward to the nearest US mail center or dental treatment facility." Numbered callouts 1-10 point to specific areas: 1 points to the "Service and Status" section; 2 points to the "Pencil Entries" section; 3 points to the last digit of the SSN; 4 points to the "Family Member Prefix Code" field; 5 points to the "Sponsor's SSN" field; 6 points to the "Patient's Full Name" field; 7 points to the "Center page; Privacy Act Statement (front), Disclosure Record (back)"; 8 points to the "Back page; Place black tape on last digit of SSN, Forensic Examination (front)"; 9 points to the "Alert box"; 10 points to the "Annual verification (ignore)" section.

Figure 1

- | | |
|--|--|
| <p>1 Service and Status</p> <p>2 Pencil Entries</p> <p>3 Place black tape on last digit of SSN</p> <p>4 Patient's Family Member Prefix Code</p> <p>5 Sponsor's SSN</p> | <p>6 Patient's Full Name</p> <p>7 Center page; Privacy Act Statement (front), Disclosure Record (back)</p> <p>8 Back page; Place black tape on last digit of SSN, Forensic Examination (front)</p> <p>9 Alert box</p> <p>10 Annual verification (ignore)</p> |
|--|--|