North Dakota State Board of Dental Examiners

PO Box 7246 ▪ Bismarck, ND 58502 ▪ Phone 701-258-8600 ▪ Fax 701-224-9824
Web www.nddentalboard.org ▪ Email ndsbde@aptnd.com

COMPLAINT FORM

Please ***type*** or ***print legibly*** and return to the above address. Form must be **NOTARIZED**.

PERSON REGISTERING COMPLAINT	
NAME	PHONE NUMBERS
ADDRESS	HOME ( )
CITY STATE ZIP	BUSINESS ( ) CELL ( )
HAVE YOU FILED ANY PREVIOUS COMPLAINTS WITH THIS BOARD? YES ☐ NO ☐	

COMPLAINT REGISTERED AGAINST:
NAME **(Please use the full name of the PERSON against whom you are filing the complaint. PLEASE DO NOT USE the name of the facility or company.)**
ADDRESS
CITY STATE ZIP
DAYTIME PHONE

DETAILS OF COMPLAINT

1. DATE OF INCIDENT _____

2. NATURE OF YOUR COMPLAINT. (Check all that apply.)

____Quality of care, competency	____ Failure to release copy of patient records
____Substance Abuse	____ Suspect insurance fraud
____Fee dispute	____ Improper prescribing of medications
____Inappropriate contact with a patient	____ Patient abandonment
____Poor communication or chair side manner	____ Other. Please describe.

_____
_____

2. Have you communicated your concern to the person or company? Yes ☐ No ☐

   If yes, on what date and by what means:

3. Did the person or the company respond? Yes ☐ No ☐

   If yes, what was said or done?

_____
_____
_____

4. Have you seen any other practitioner(s) prior to or after in connection with this complaint? Yes ☐ No ☐ (If yes, please provide name and address and phone number of the practitioner below):

_____

5. **STATE YOUR COMPLAINT:** (Please provide a clear and concise description of the nature of your complaint, including dates of occurrence, the names and telephone numbers of witnesses and copies of documents pertinent to your complaint including contracts, photographs, x-rays, and patient records, insurance records, etc.)

_____

_____

_____

_____

_____

_____

_____

_____

(IF MORE SPACE IS NEEDED, PLEASE ATTACH ADDITIONAL SHEETS OF PAPER)

ALL COMPLAINTS MUST BE NOTARIZED.

STATE OF _____)
)
COUNTY OF _____)

On this _____th day of _____, 20___ before me personally appeared _____known to me to be the person who is described in and who executed the foregoing instrument, and acknowledged to me that they executed the same.

_____
Notary Public, County of _____,
My commission expires: _____

I AFFIRM THE PRECEDING AND IT IS TRUE TO THE BEST OF MY INFORMATION AND BELIEF**. I am filing this complaint to notify the Board of the activities of this practitioner so that it may be determined if discipline is warranted. I understand that a copy of this complaint may be provided to the licensee.**

_____ _____
SIGNATURE OF COMPLAINANT DATE

RELEASE OF DENTAL AND/OR MEDICAL RECORDS

(*Failure to sign the release may result in a delay of the investigation of your complaint.*)

I hereby authorize and direct you to release to the Dental Board or its agents all records and information, including x-rays and models, of any treatment and/or consultation of NAME OF PATIENT _____ _____ as may be requested by the Board or its agent. A copy of my signature on this release shall be authorization and direction to release such records and information as is appropriate to the investigation of the complaint. Only individuals directly involved in the complaint process will have access to these records. Copies of this authority may be utilized with the same effectiveness as an original. **If this complaint involves a minor, this release must be signed by the minor's parent or legal guardian, and authorizes the release of the minor's dental records to the North Dakota State Board of Dental Examiners and its agents for investigative purposes.**

I also hereby consent to the release of my identity and/or records to other state licensing boards and/or law enforcement agencies.

Date: _____ Signature: _____