North Dakota State Board of Dental Examiners

PO Box 7246 ▪ Bismarck, ND 58507
Phone 701-258-8600 ▪ Email info@nddentalboard.org
Web https://www.nddentalboard.org

COMPLAINT FORM

Please note that the Board generally **does not have the authority to require dental staff to provide refunds or to require patients to pay invoices.** If you seek a monetary result, you may wish to contact an attorney.

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

PERSON REGISTERING COMPLAINT	
NAME	PRIMARY PHONE
ADDRESS	EMAIL ADDRESS
CITY STATE ZIP	May we communicate and sent materials via Email? YES ☐ NO ☐
HAVE YOU FILED ANY PREVIOUS COMPLAINTS WITH THIS BOARD? YES ☐ NO ☐	
COMPLAINT REGISTERED AGAINST	
NAME: **(Name of the PERSON you are filing the complaint against, and not the name of the business or office)**	
ADDRESS:	
CITY: STATE: ZIP:	
DAYTIME PHONE:	

DETAILS OF COMPLAINT

1. DATE(S) 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 in space below

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

   If yes, on what date and by what means: _____

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

   If yes, what was said or done?

5. 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)

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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. THIS FORMS MUST BE NOTARIZED)

STATE OF _____)
ss.)
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 will 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.

Signature: **Date:** / /