South Dakota State Board of Dentistry

PO Box 1079, 116 N. Euclid Ave., Pierre, SD 57501-1079
Ph: 605-224-1282 Fax: 1-888-425-3032
e-mail: contactus@sdboardofdentistry.com www.sdboardofdentistry.com

Complaint Form

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

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 REGISTERD AGAINST*: (Please use the full name of the PERSON and FACILITY against whom you are filing the complaint.)*		
NAME		DAYTIME PHONE
FACILITY		
ADDRESS		
CITY	STATE	ZIP

DETAILS OF COMPLAINT

1. DATE OF INCIDENT: _____/_____/_____

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

_____ Quality of care, competency	_____ Substance Abuse
_____ Fee Dispute	_____ inappropriate contact with a patient
_____ Poor communication or chair side manner	_____ Failure to release copy of patient records
_____ Suspect insurance fraud	_____ Improper Prescribing of medications
_____ Patient abandonment	_____ Other. Please describe.

_____
_____

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, ADDRESS AND PHONE NUMBER OF THE PRACTITIONER BELOW.
   _____
   _____
   _____

STATE YOUR COMPLAINT: (Please provide a clear and concise description of the nature of your complaint, including dates of occurrence, times, place and persons involved. Please include the names and telephone numbers of witnesses, if applicable). **If more space is needed, please attach additional sheets of paper.**

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

The Board of Dentistry cannot register your complaint or begin the investigative process without a signed Release of Dental and /or Medical Records. Failure to sign the release will result in a delay of the investigation of your complaint.

I hereby authorize and direct you to release to the SD Board of Dentistry 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 compliant 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 South Dakota State Board of Dentistry 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: _____