South Dakota State Board of Dentistry

P.O. Box 1079, 1351 N. Harrison 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 REGISTERED 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
- ☐ Fee Dispute
- ☐ Poor communication or chair side manner
- ☐ Suspect insurance fraud
- ☐ Patient abandonment
- ☐ Substance Abuse
- ☐ Inappropriate contact with a patient
- ☐ Failure to release copy of patient records
- ☐ Improper Prescribing of medications
- ☐ 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, PROVIDE THE NAME, ADDRESS AND PHONE NUMBER OF THE PRACTITIONER(S) 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 verify that I have read the foregoing complaint and the same is true to the best of my knowledge, information and belief. I hereby waive any right of confidentiality or privilege under state law, federal law or the law of the land. I specifically acknowledge and understand that the Board may disclose confidential and privileged information as the Board or its staff deem necessary to investigate and process this complaint. I understand that a copy of this complaint will be provided to the licensee.

_____ _____

Signature of Complainant Date

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RELEASE OF DENTAL/MEDICAL RECORDS AND BILLING STATEMENTS

The Board of Dentistry generally cannot investigate a complaint without receiving and reviewing records relevant to the treatment referenced in the complaint. And the Board cannot obtain records required for its investigation without a signed Release of Dental/Medical Records and Billing Statements from the patient who received treatment relevant to the complaint. For this reason, the Board requests you sign and return this Release if you are a patient who received treatment referenced in a Complaint the Board has received. Please note that a failure to sign and return this Release will result in a delay of the investigation of the complaint. Thank you for your cooperation.

I hereby authorize and direct you to release to the South Dakota State Board of Dentistry or its agents all dental and medical records (including, but not limited to x-rays and models) and billing statements for any treatment and/or consultation of NAME OF PATIENT _____(DOB: _____) as may be requested by the Board or its agents. 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. Copies of this authority may be utilized with the same effectiveness as an original.

I also hereby consent to the release of my identity and records to agents of the Board involved in the investigation, other state licensing boards and law enforcement agencies.

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 and medical records and billing statements to the South Dakota State Board of Dentistry and its agents for investigative purposes.

The above named patient is a minor and I am the:

- ☐ Patient's Mother
- ☐ Patient's Father
- ☐ Patient's Legal Guardian

Date:_____ Signature:_____

Printed Name:_____