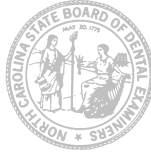


NORTH CAROLINA STATE BOARD OF DENTAL EXAMINERS

507 Airport Boulevard
Suite 105
Morrisville, NC 27560
(919) 678-8223



COMPLAINT FORM

INSTRUCTIONS

- 1) Please fill in the information listed below. Then answer the questions and state your complaint on the reverse side of this form.
- 2) A copy of your complaint will be given to the dentist being complained against.
- 3) Any person who files a complaint must be willing to appear as a witness, testify and be cross-examined concerning the allegations made in the complaint.

IMPORTANT

The North Carolina State Board of Dental Examiners investigates complaints against dentists and dental hygienists accused of violating the Dental Laws of North Carolina. If the Board of Dental Examiners finds that a licensee has violated the Dental Laws, it may discipline the dentist/dental hygienist by taking action against the license (i.e., suspend or revoke the license.) The Board does not have statutory authority to award monetary damages for pain and suffering, or to require that a dentist/dental hygienist refund fees or pay for any re-treatment.

The North Carolina State Board of Dental Examiners cannot give legal advice or act as your attorney; nor does the Board have jurisdiction over fee disputes.

- You must complete all questions below.
- You must describe the complaint in a clear and concise manner.
- You must sign the complaint form or it will be returned to you.
- If quality of care is an issue, a clinical evaluation (dental examination) MAY be requested. This will be done at no cost to you by an impartial, Board-approved Evaluator.
- You must be willing to participate in a hearing, should one become necessary.

TYPE OR PRINT CLEARLY IN INK

Your Full Name Mr./Ms. (Circle One)	
Home Address (Street)	Home Phone
Address (City, State, Zip Code)	Work Phone
Most Convenient Time & Place To Be Interviewed	

(OVER)

LICENSEE(S) COMPLAINED AGAINST

DENTIST'S NAME: _____

Address: _____

OTHER: _____

OTHER: _____

PLEASE ANSWER ALL QUESTIONS COMPLETELY AND CONCISELY

1) Have you contacted the dentist or dental hygienist regarding your complaint? **YES** **NO**

If "yes", what were you told? _____

If "no", why not? _____

2) What dental treatment did you receive? _____

Date(s) of treatment: _____

3) If your complaint involves dental treatment, were you seen by another dentist for follow-up care? **YES** **NO**

If "yes", give the name and address of all dentists, physicians, hospitals and clinics visited in connection with your complaint.

4) In the space provided, state in full all true facts upon which your complaint is based, including names, dates of treatment, and any other pertinent information. If necessary, use additional sheets of paper. Please attach copies of any documents which support your complaint (letters, bills, x-rays, etc.)

THE NORTH CAROLINA STATE BOARD OF DENTAL EXAMINERS

**507 Airport Boulevard, Suite 105
Morrisville, North Carolina 27560
(919) 678-8223
Fax (919) 678-8472**

**MEDICAL/DENTAL RECORDS RELEASE AUTHORIZATION
AND
CERTIFICATION**

I HEREBY CERTIFY THAT THE FACTS SET FORTH IN THE COMPLAINT ARE TRUE TO MY KNOWLEDGE, OR REASONABLY BELIEVED BY ME TO BE TRUE. THIS STATEMENT IS GIVEN FREELY AND VOLUNTARILY.

IN ADDITION, I HEREBY AUTHORIZE AND DIRECT ANY DENTIST, PHYSICIAN, HOSPITAL OR CLINIC WHO HAS EXAMINED OR PROVIDED CARE TO ME IN CONNECTION WITH MY COMPLAINT, TO RELEASE THE ORIGINAL OR A COPY OF MY DENTAL AND OR MEDICAL RECORDS TO THE NORTH CAROLINA STATE BOARD OF DENTAL EXAMINERS FOR THE PURPOSE OF INVESTIGATING AND RESOLVING MY COMPLAINT. THIS INFORMATION SHOULD INCLUDE, BUT NOT BE LIMITED TO, PATIENT MEDICAL HISTORY, PATIENT CHART, RADIOGRAPHS, STUDY MODELS, OPERATIVE NOTES, DISCHARGE SUMMARIES, OFFICE NOTES, EXAMINATION RESULTS AND TEST RESULTS.

I UNDERSTAND THAT THIS INFORMATION MAY BECOME PUBLIC RECORD SHOULD THIS MATTER GO TO A HEARING BEFORE THE NORTH CAROLINA STATE BOARD OF DENTAL EXAMINERS. THIS AUTHORIZATION WILL EXPIRE WITHIN TWO (2) YEARS FROM THE DATE OF MY SIGNATURE.

✓ PRINT FULL NAME OF PATIENT (if different from complainant)

✓ PATIENT'S DATE OF BIRTH

✓ PRINT FULL NAME OF COMPLAINANT

✓ TODAY'S DATE

✓ SIGNATURE OF COMPLAINANT

North Carolina

_____ **County**

I, _____, a Notary Public for said County and State, do hereby certify that _____ personally appeared before me this day and acknowledged the due execution of the foregoing instrument.

Witness my hand and official seal, this the _____ day of _____, 20_____.

(OFFICIAL SEAL)

Notary Public

My Commission Expires _____, 20_____.

When complete, return entire complaint form to the Board at the address listed above.