COMPLAINT FORM

Please Return to:

IOWA DENTAL BOARD
400 S.W. 8th St., Suite D; Des Moines, IA 50309-4687
Phone: 515-281-5157; Fax: 515-281-7969

PERSON REGISTERING COMPLAINT

NAME:			HOME PHONE:
ADDRESS:			WORK PHONE:
CITY:	STATE:	COUNTY:	ZIP CODE:
RELATIONSHIP TO PATIENT:			
PATIENT'S NAME:			HOME PHONE:
ADDRESS: (if different than address listed above)			WORK PHONE:
CITY:	STATE:	COUNTY:	ZIP CODE:

COMPLAINT FILED AGAINST

NAME:			BUSINESS PHONE:
ADDRESS:			
CITY:	STATE:	COUNTY:	ZIP CODE:
APPROXIMATE TREATMENT DATE:			
How long have you been a patient of the practitioner against whom you are filing the complaint?			
Have you seen any other practitioner(s) prior to or after in connection with this complaint? (If yes, please supply information below.)			

NAME:	NAME:
ADDRESS:	ADDRESS:
CITY/STATE/ZIP CODE:	CITY/STATE/ZIP CODE:
BUSINESS PHONE:	BUSINESS PHONE:
APPROXIMATE TREATMENT DATE(S):	APPROXIMATE TREATMENT DATE(S):

NATURE OF COMPLAINT

Check all that apply:

- ☐ POOR DENTAL TREATMENT
- ☐ ETHICAL
- ☐ FEE DISPUTE
- ☐ COMPETENCY
- ☐ REFUSAL TO TRANSFER DENTAL RECORDS
- ☐ PRACTICING UNDER THE INFLUENCE OF DRUGS AND/OR ALCOHOL
- ☐ BILLING FOR SERVICES NOT RENDERED
- ☐ OTHER:_____

Below, please explain in your own words, an account of what happened regarding the incident in question:

(For more space, feel free to use the back of this form, if available, or additional pages as needed.)

I certify that the information given herein is true and correct to the best of my knowledge. With this signature, I authorize the release of my dental records, when necessary, from any treating practitioner to the Iowa Dental Board and its agents for investigative purposes. 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, when necessary, from any treating dentist to the Iowa Dental Board and its agents for investigative purposes.

Signature Date

Please attach copies of related documents. DO NOT SEND ORIGINALS!