OKLAHOMA STATE BOARD OF DENTISTRY

2920 N LINCOLN BLVD., STE. B
OKC, OK 73105
PHONE: (405) 522-4844
FAX: (405) 522-4614
WEBSITE: www.ok.gov/dentistry

COMPLAINT FORM

INFORMATION ABOUT YOU:			
NAME:			
ADDRESS:			
CITY:	STATE:	ZIP:	
DAYTIME PHONE NUMBER:			
EMAIL ADDRESS:			
IF THIS MATTER GOES TO HEARING, WOULD YOU BE WILLING TO TESTIFY?		Y	N
HAVE YOU CONTACTED THE DENTIST ABOUT YOUR COMPLAINT?		Y	N
INFORMATION ABOUT THE DENTIST:			
NAME OF DENTIST:			(Please list dentist name)
NAME OF DENTAL OFFICE:			
ADDRESS:			
CITY:	STATE:	ZIP:	
PHONE NUMBER:			

NATURE OF COMPLAINT

Please check all that apply:

Incompetence		Malpractice	
Sexual Misconduct		Substance Abuse	
Fraud		Failure to Provide/Transfer Records	
Medications		False/Misleading Advertisement	

*Please note that we do not have the authority to investigate fees you believe are too high or to intervene in fee disputes; however, we can investigate complaints involving fraudulent billing.

(NEXT PAGE) **PLEASE PRINT OR TYPE CLEARLY. PLEASE PROVIDE, IN YOUR OWN WORDS, A DETAILED STATEMENT OF YOUR COMPLAINT. BE AS SPECIFIC AS POSSIBLE ABOUT YOUR CONCERNS.**

***If you are requesting your medical records in this complaint, you will be required to complete the 3rd page of this complaint as well as get it notarized since you are requesting HIPAA protected documents.*

(Attach additional pages if necessary)

The information included herein is true and correct to the best of my knowledge and belief.

Signature

Date Signed

RELEASE OF INFORMATION/RECORDS AUTHORIZATION

I, _____, do hereby authorize any dentist, physician or other healthcare provider, clinic, custodian of medical or dental records, laboratory, insurance company, governmental agency, dependents, or who has records pertaining to same relating to dental procedures to furnish to the Oklahoma Board of Dentistry or any of its authorized agents or employees presenting this Release to them, any oral or written statements, x-rays, forms or any records whatsoever with respect to any dental-related history, consultation, condition, prescription, treatment or payment of any dental claim.

I further authorize any of the above persons to make available to the Oklahoma Board of Dentistry, its authorized agent or employee, copies of any information possessed or maintained by them.

An exact copy of this authorization shall be accepted the same as the original in all instances.

Date: _____ _____ Complainant/Responsible Party

Name and Address of Patient: _____

DOB: _____ Telephone: _____

Notary:
State of _____)
County of _____)

Subscribed and sworn before me this _____ day of _____, 20___.

Notary Public: _____

My Commission Expires: _____

NOTICE: If a notary is not available, please have this authorization witnessed.

Witness Name and Address: _____

_____

_____

_____ _____
Signature Date

Date Released: _____

Agent: _____

OKLAHOMA BOARD OF DENTISTRY
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