WEST VIRGINIA BOARD OF DENTISTRY
PO Box 1447
Crab Orchard, WV 25827
PHONE: (304) 252-8266 TOLL FREE (877)914-8266
FAX: (304) 253-9454
wvbde@suddenlinkmail.com

COMPLAINT FORM

Name of Dentist or Dental Hygienist:_____

Address:_____ Email:_____

_____

Name of person filing complaint:_____

Address:_____

_____

Daytime Phone:_____ Alternate Phone:_____

Patient's first and last name if other than person filing complaint:

_____

Patient's Date of Birth: _____

Relationship to Patient: ☐ Self ☐ Parent ☐ Son/Daughter ☐ Spouse
☐ Other _____

Date of Treatment: _____

PLEASE NOTE:

The West Virginia Board of Dentistry regulates the practice of dentistry and dental hygiene in West Virginia. The Board can discipline a licensed dentist or dental hygienist who violates the law or deviates from the standard of care for dentistry. **The Board has no jurisdiction over billing or fee disputes, insurance coverage, personality conflicts, scheduling issues, or employee/employer disputes.**

In order to ensure procedural due process, this complaint will be shared with the dentist or dental hygienist for his or her response. **ONCE COMPLETED, YOUR SIGNED COMPLAINT IS A MATTER OF PUBLIC RECORD.**

NATURE OF COMPLAINT IN DETAIL: Please type or clearly print your concerns or explain the issues involved in your complaint. Attach additional pages and supporting documentation as necessary.

PLEASE LIST ANY PRIOR AND/OR SUBSEQUENT TREATING PRACTITIONERS RELATIVE TO YOUR COMPLAINT.

Name:_____ ☐ Prior treating ☐ Subsequent
Address:_____
_____

Name:_____ ☐ Prior treating ☐ Subsequent
Address:_____
_____

Name:_____ ☐ Prior treating ☐ Subsequent
Address:_____
_____

By signing this complaint form, I hereby certify that the information provided is complete and true to the best of my knowledge. Further, I will voluntarily appear and testify to the facts in this complaint if called upon by the West Virginia Board of Dentistry.

Date:_____ Signature: _____
Patient or Legal Guardian

Please sign the release on the next page and return with your complaint form. Failure to sign and return the release may result in a delay of the investigation of your complaint.

FOR OFFICE USE ONLY

Complaint No.: _____ Date Received: _____

License No.: _____ Receipt Letter Sent: _____
Licensee Letter Sent: _____ Violation: _____

Disposition: _____ Disposition Date: _____

WEST VIRGINIA BOARD OF DENTISTRY

RELEASE OF DENTAL/MEDICAL RECORDS FROM DENTAL/MEDICAL PROVIDERS OR FACILITIES

I hereby authorize and direct release to the West Virginia Board of Dentistry or its agents all records and information, including billing information, x-rays and models of any treatment and/or consultation of:

NAME OF PATIENT:_____

DATE OF BIRTH:_____

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 appropriate to the investigation of the complaint. My healthcare records are **not** public record and are requested solely for the purpose of the investigation of the complaint. Only individuals directly involved in the complaint process will have access to these records. A photo copy of this authorization shall be deemed as effective as an original.

Date: _____ Signature:_____
Patient or Legal Guardian of Patient

THIS AUTHORIZATION SHALL BE EFFECTIVE FOR ONE YEAR FROM THE DATE OF SIGNING.