STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS,CONSUMER SERVICES, AND HOUSING AGENCY • GOVERNOR EDMUND G. BROWN JR.

Dental Board of California
2005 Evergreen Street, Suite 1550, Sacramento, California 95815
P (916) 263-2300 | F (916) 263-2140 | www.dbc.ca.gov

CONSUMER COMPLAINT FORM

PLEASE PRINT OR TYPE

COMPLAINT REGISTERED AGAINST

Name:			Name of Dental Office:
Address:			
City:	State:	Zip Code:	Office Phone Number:

PERSON REGISTERING COMPLAINT

Mr. ☐ Mrs. ☐ Ms. ☐	Name:		Relationship to Patient:
Address:			Home Phone Number:
City:	State:	Zip Code:	Work Phone Number:
Patient Name:		☐ Male ☐ Female	Patient's Date of Birth:
Legal authority to act on patient's behalf?			
Has patient been examined or treated by another dentist for this same complaint? YES ☐ NO ☐ If yes, please provide full names and addresses on the back of this form.			

DESIRED OUTCOME OF THIS COMPLAINT

DETAILS OF COMPLAINT

Dates of Visits:

State your complaint in detail:

NOTICE: As much information as possible should be provided, in addition to any supporting documents pertaining to your specific complaint. Failure to provide sufficient information or documentation may prevent or delay the review of your complaint. The information will be used to determine whether a violation of law has occurred. If a violation is substantiated, the information may be transmitted to other governmental agencies, including the Attorney General's Office. The Dental Board of California does not have jurisdiction over fee disputes or office business procedures.

DO NOT WRITE IN THIS SPACE

Signature_____ Date_____

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SUPPLEMENTAL COMPLAINT INFORMATION

PLEASE PROVIDE THE NAME, ADDRESS, TELEPHONE NUMBER AND DATE OF VISIT TO ANY OTHER DENTISTS YOU HAVE SEEN SINCE BEING TREATED BY THE SUBJECT OF YOUR COMPLAINT.

1. _____
_____ SUITE # _____
_____
PHONE # _____ DATE(S) _____

2. _____
_____ SUITE # _____
_____
PHONE # _____ DATE(S) _____

3. _____
_____ SUITE # _____
_____
PHONE # _____ DATE(S) _____

4. _____
_____ SUITE # _____
_____
PHONE # _____ DATE(S) _____

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Authorization for Release of Dental/Medical Patient Records

Patient Name: _____ Date of Birth: _____

AUTHORIZATION TO RELEASE INFORMATION: I, the undersigned, authorize any physician, dentist, medical practitioner, hospital, clinic or other dental or dental related facility having records (original and/or electronic) available as to diagnosis, treatment and prognosis with respect to any dental or medical condition and/or treatment of me (or the patient) to release to the Dental Board of California or any Board representatives, related local, state and federal governmental agencies, including but not limited to, investigators and legal staff.

I understand that this information will be maintained in confidence, and will be used solely in conjunction with any investigation and possible legal proceeding regarding any violations of California laws and regulations. I further agree to allow the Board, Board representatives and related governmental agencies, to process and possibly file other charges based on my complaint.

I also understand that the subject of my complaint (the dentist or dental auxiliary I am complaining about) may receive a copy of my complaint and records pursuant to the Administrative Procedures Act and the Information Practices Act.

I agree that a photocopy of this Authorization shall be as valid as the original. This Authorization shall remain valid until the Dental Board of California or other authorized Government Agency completes its review and the proceedings arising out of the investigation.

I understand that I have a right to receive a copy of this authorization if requested by me.
Patient/Guardian

Signature:_____Date:_____

Attach written proof of authorization to act on patient's behalf.

This release is in compliance with the requirements of Civil Code § 56.11.