

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:

- | | |
|--|--|
| <input type="checkbox"/> POOR DENTAL TREATMENT
<input type="checkbox"/> ETHICAL
<input type="checkbox"/> FEE DISPUTE
<input type="checkbox"/> COMPETENCY
<input type="checkbox"/> REFUSAL TO TRANSFER DENTAL RECORDS | <input type="checkbox"/> PRACTICING UNDER THE INFLUENCE OF DRUGS AND/OR ALCOHOL
<input type="checkbox"/> BILLING FOR SERVICES NOT RENDERED
<input type="checkbox"/> OTHER: _____ |
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