



IDAHO STATE BOARD OF DENTISTRY

◆ PO BOX 83720 BOISE, ID 83720-0021 ◆ PHONE: (208) 334-2369 ◆ FAX: (208) 334-3247
◆ WEBSITE: www.isbd.idaho.gov ◆ EMAIL: sbdinfo@isbd.idaho.gov

ADVISORY NOTICE REGARDING COMPLAINTS

The Idaho State Board of Dentistry enforces the provisions of the Idaho Dental Practice Act and its Administrative Rules by the licensure and regulation of dentists/dental specialists and dental hygienists in the state of Idaho. A person who believes that a dentist/dental specialist or dental hygienist has violated the standards of the Dental Practice Act or the Administrative Rules can file a written complaint with the Idaho Board of Dentistry. Please be advised of the following:

- If you have a complaint against a dentist/dental specialist or dental hygienists, you must fill out the complaint form. Please include any supportive documents you may have, including dental records (and medical records if appropriate). All complaints must be signed. The Board will not review unsigned complaints, verbal complaints, or complaints filed anonymously.
- The act of filing a complaint does not assure or imply that disciplinary action will be taken against the licensee.
- The role of the Board is to determine what is necessary for public protection, and is not to advocate on behalf of an individual complainant.
- Filing a complaint with the Idaho Board of Dentistry does not preclude you from filing a separate legal action. If you believe your complaint may constitute a criminal violation, please contact your local law enforcement agency regarding the procedure to file a criminal complaint. If you wish to pursue civil remedies, please contact a private attorney for guidance.
- The Board of Dentistry's jurisdiction is limited. The Board does not review fee disputes or monetary issues between a patient and a dentist, personality conflicts, or concerns with dental insurance carriers.
- Complaints against dentists/dental specialists related to a fee dispute may possibly be resolved by the Peer Review Committee of Idaho State Dental Association (ISDA). The ISDA is a professional society, completely separate and independent of the Idaho Board of Dentistry. If your complaint involves a fee dispute, please contact the ISDA directly at (208) 343-7543 for more information.
- If your complaint falls within the Board of Dentistry's jurisdiction, a copy of your complaint will be provided to the dentist/dental specialist or dental hygienist you are complaining against in order to allow them the opportunity to provide a written response to your complaint and, if necessary, copies of your applicable dental records.
- If your complaint requires further investigation it will be provided to a Board of Dentistry investigator for further information gathering. The Board of Dentistry's investigator may contact you, the dentist/dental specialist or dental hygienist you complained against and any follow-up practitioners that you identified in your complaint.
- If your complaint does not require further investigation or when the additional investigation is completed, all available information will be provided to the members of the Board of Dentistry for their review.
- The members of the Board of Dentistry review complaints and make disciplinary decisions at their quarterly meetings. Because the Board of Dentistry's complaint process is detailed and carefully conducted, you should expect that it would take some period of time to complete.
- You will periodically be informed in writing regarding the status of your complaint and subsequently the Board of Dentistry's decision regarding your complaint.



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COMPLAINT FORM

PATIENT INFORMATION:		
Full Name (First, Middle, Last):		
Street Address:		
City:	State:	Zip:
Phone Number:		Email Address:
Relationship To Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Son/Daughter <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Other: _____		
SUBJECT OF COMPLAINT:		
The Subject of the Complaint is a: <input type="checkbox"/> General Dentist <input type="checkbox"/> Dental Specialist <input type="checkbox"/> Registered Dental Hygienist		
Name of Licensee:		
Street Address:		
City:	State:	Zip:
LIST ALL OTHER LICENSEES (DENTAL OR MEDICAL)* WHO HAVE PROVIDED PRIOR AND/OR SUBSEQUENT TREATMENT OR SECOND OPINIONS IN CONNECTION WITH THIS COMPLAINT:		
Full Name:		
Street Address:		
City:	State:	Zip:
Phone Number:		<input type="checkbox"/> Prior Treating <input type="checkbox"/> Subsequent Treating
Full Name:		
Street Address:		
City:	State:	Zip:
Phone Number:		<input type="checkbox"/> Prior Treating <input type="checkbox"/> Subsequent Treating
Full Name:		
Street Address:		
City:	State:	Zip:
Phone Number:		<input type="checkbox"/> Prior Treating <input type="checkbox"/> Subsequent Treating

**Please use a separate sheet of paper to list additional licensees if needed.*

NATURE OF THIS COMPLAINT (CHECK ALL THAT APPLY)*:

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Crown and Bridge | <input type="checkbox"/> Dentures | <input type="checkbox"/> Failure to Release Records | <input type="checkbox"/> Fillings |
| <input type="checkbox"/> Implants | <input type="checkbox"/> Inappropriate Physical Contact | <input type="checkbox"/> Insurance Fraud | <input type="checkbox"/> Misdiagnosis |
| <input type="checkbox"/> Oral Surgery | <input type="checkbox"/> Orthodontics | <input type="checkbox"/> Patient Abandonment | <input type="checkbox"/> Periodontal Treatment |
| <input type="checkbox"/> Root Canal | <input type="checkbox"/> Substance Abuse | <input type="checkbox"/> Unnecessary Treatment | <input type="checkbox"/> Other (Describe Below): |

****Fee disputes do not fall under the jurisdiction of the Idaho Board of Dentistry.***

Have you attempted to contact the licensee concerning your complaint?

- Yes No

If Yes, please provide the date(s): _____

Would you be willing to testify if this matter goes to a formal hearing?

- Yes No

If No, please provide a brief explanation: _____

Have you read the “Advisory Notice Regarding Complaints”? It is recommended but not required that you review this information. This notice provides general information about complaints, the Idaho Board of Dentistry’s legal authority, and information about the complaint process.

- Yes No

What action are you requesting of the Idaho Board of Dentistry? _____

**AUTHORIZATION FOR RELEASE
OF MEDICAL RECORDS AND MEDICAL INFORMATION**

Patient's Full Name (First, Middle, Last):	
Relationship To Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Son/Daughter <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Other: _____	
Patient's Date of Birth:	Date(s) of Service:

I hereby authorize and direct any dentist, physician, or other person who provided dental and/or medical care during the timeframe listed above, to release and disclose any and all dental and/or medical records, reports, and information to the Idaho State Board of Dentistry or to such other representative of the Idaho State Board of Dentistry as may be designated, for the specific purpose of addressing concerns relevant to my dental care and treatment.

I further authorize and direct any dentist, physician, or other person or entity that has such information to consult with or discuss such information with the Idaho State Board of Dentistry or to such other representative of the Idaho State Board of Dentistry as may be designated.

If the dental and/or medical records, reports, and information to be disclosed relate to a person other than the undersigned, by execution hereof I acknowledge that I have the legal authority to provide a valid consent for release of any and all dental and/or medical records, reports, and information.

I further consent that a photocopy of this Authorization may be used in lieu of the original hereof and shall be considered valid for one (1) year from the date of my signature below. This authorization, however, is revocable upon receipt of my written request by the Idaho State Board of Dentistry.

Dated this _____ day of _____, 20____.

Patient/Legal Guardian Printed Name

Patient/Legal Guardian Signature