



ARIZONA STATE BOARD OF DENTAL EXAMINERS

4205 North 7th Avenue, Suite 300 • Phoenix, Arizona 85013

Telephone (602) 242-1492 • Fax (602) 242-1445

www.dentalboard.az.gov

The following are options available in attempting to resolve problems with a dentist, dental hygienist, or denturist:

THROUGH THE ARIZONA STATE BOARD OF DENTAL EXAMINERS:

OPTION 1

Discuss the complaint with the dentist, dental hygienist, or his or her supervisor. Dentists and dental hygienists are in most cases business people and are sensitive to complaints about their services. You may feel reluctant to approach the dentist or dental hygienist or his or her supervisor about your dissatisfaction, but many complaints are resolved in this manner and it might be your most convenient way to proceed.

OPTION 2

The Arizona Dental Association has a peer review process. That process is confidential and available provided the complaint falls within peer review guidelines. For more information about this process and its guidelines, contact the AzDA Peer Review Committee at 480 – 344 - 5777 (www.azda.org)

OPTION 3

A consumer may have the option of retaining an attorney for the purposes of bringing a personal injury lawsuit or other legal action against a dentist or a dental hygienist.

OPTION 4

File a complaint with the Arizona State Board of Dental Examiners. In deciding upon discipline, one of the many options available to the Board is the awarding of restitution to the patient and/or insurance company. However, the resolution of a complaint does not guarantee any restitution will be awarded to the complainant.

HOW LONG DOES A BOARD COMPLAINT TAKE?

The resolution of a Board complaint is not necessarily a quick process. Investigations and the review of reports may take two to four months or longer. Investigations involving multiple allegations and many witnesses may require additional time. If a formal administrative hearing is required this may take up to a year or more.

Please also be aware that failing to provide the Board with your identifying information may result in the Board not being able to adequately investigate alleged violations. It also prohibits Board staff from providing you with updates regarding the Board's review and resolution of your complaint.

Issues which are NOT within the jurisdiction of the Board include:

- ✓ **Billing or fee disputes** (i.e., the amount a dentist charges for services)
- ✓ **Insurance Coverage**
- ✓ **Personality conflicts**
- ✓ **Bedside manner or rudeness of practitioners** (such as the dentist or his/her office staff's attitude or professionalism)
- ✓ **HIPAA Violations** (This falls under the jurisdiction of the Federal Government.)
- ✓ **Scheduling Issues**
- ✓ **Business or contract disputes** between dentists or other individuals.
- ✓ **Employee/Employer disputes**

COMPLAINT FORM:

While we do not wish to complicate the filing of complaints, we ask that you submit your complaint in writing so that it can be properly evaluated. Please provide as much detail as you can regarding all facts which relate to the complaint, including references to records which you may have or know about, and any attempts you may have already made to resolve your complaint with the provider.

If it appears your complaint falls within the Board's jurisdiction and appears to show the existence of grounds for disciplinary action, an investigation will be opened and you will become a witness to the investigation.

Please be advised in order to investigate a complaint, the Board will subpoena all relevant patient records from the dentist who is the subject of the complaint and any dentists who provided prior or subsequent treatment. The Board will maintain all records as part of a confidential investigative file and they will be available for review by the Board, its investigators and the dentist who is the subject of the complaint and his/her attorney.



ARIZONA DENTAL BOARD COMPLAINT FORM

Case Number _____

COMPLAINANT/REPORTER

DATE: _____

Your Name: _____
Last First M.I. Ms./Mr./Mrs.

Address: _____
Street Address Apartment/Unit #

City State ZIP Code

E-mail address: _____

Home Telephone: () _____ Work Telephone: () _____ Best Time to Call: _____

SUBJECT OF COMPLAINT/REPORT DENTIST INFORMATION

Dentist's Name: _____
Last First M.I.

Practice Address: _____
Street Address Apartment/Unit #

City State ZIP Code

Work Telephone: () _____

PATIENT INFORMATION (Complete this section if Patient is not the same as Complainant/Reporter)

Name of Patient: _____
Last First M.I.

Address: _____
Street Address Apartment/Unit #

City State ZIP Code

Home Telephone: () _____ Work Telephone () _____

YOUR RELATIONSHIP TO PATIENT

- Self Parent Son/Daughter Spouse Brother/Sister Friend *** Legal Guardian/provide court documents
 Other

NATURE OF COMPLAINT/REPORT (Please check all that apply).

- Crown and Bridge Root Canal Periodontal treatment Inappropriate prescribing of medication
 Substance Abuse Mis-diagnosis of a condition Inappropriate Physical contact with a patient
 Insurance Fraud Failure to Release records Patient Abandonment Fillings Unnecessary Treatment
 Orthodontics Oral Surgery Implants Dentures Problem other than listed above_____

Have you attempted to contact the practitioner concerning your complaint?

- Yes Date: No

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

- Yes No

If the incident involved criminal conduct, you should contact your local law enforcement authority. Have you contacted your local law enforcement authority?

- Yes No

If yes, state the name of the person or office that you contacted._____ When did you make this contact?
_____ Please give case number if available._____

***NOTE: If other than patient or parent of a minor patient, please provide documentation indicating appointment

YOU MUST LIST ANY PRIOR AND/OR SUBSEQUENT TREATING DENTISTS RELATIVE TO YOUR COMPLAINT.

Full Name:	Address:	Telephone Number:	<input type="checkbox"/> Prior treating	<input type="checkbox"/> Subsequent treating
Full Name:	Address:	Telephone Number:	<input type="checkbox"/> Prior Treating	<input type="checkbox"/> Subsequent Treating
Full Name:	Address:	Telephone Number:	<input type="checkbox"/> Prior Treating	<input type="checkbox"/> Subsequent Treating

*** Use a separate sheet to list additional dentists

Please give full details of your complaint/report: include facts, details, dates, locations, etc. Please attach copies of medical records, correspondence, contracts, amount paid for disputed treatment and any other documents that will help support your complaint. (Attach additional sheets if necessary).

I have attached copies of dental records, correspondence, contracts, and any other documents that will help support my complaint.

VERIFICATION STATEMENT

IN ACCORDANCE WITH THE REQUIREMENTS OF ARIZONA REVISED STATUTES (A.R.S. §32-1263.02(b)), I HEREBY VERIFY THAT THE FOREGOING STATEMENTS IN THIS STATEMENT ARE TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND RECOLLECTION AND DO AFFIRM THAT THE COMPLAINT IS FILED IN GOOD FAITH.

SIGN & DATE: _____