OHIO STATE DENTAL BOARD
COMPLAINT INFORMATION

77 South High Street, 17th Floor
Columbus, Ohio 43215-6135
PH: 614-466-2580 FX: 614-752-8995
www.dental.ohio.gov
dental.board@den.ohio.gov

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

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
Your local Dental Association may have a peer review process. The process is confidential and available provided the complaint falls within peer review guidelines. For more information about this process and its guidelines, contact your local Dental Association Peer Review Committee.

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 Ohio State Dental Board.

The Board investigates the following:

1. Improper Prescribing, Dispensing, or Administering of Drugs
2. Minimal Standards of Care
3. Fraud, Misrepresentation, or Deception
4. Lewd and Immoral Conduct
5. Unlicensed Practice/ Permitting
6. Criminal Convictions
7. Impairment of Ability of Practice
8. Infection Control Violations
9. Continuing Education Violations
10. Miscellaneous Violations

If the Board finds that there has been a violation of the Dental Practice Act, it may choose one of the following formal disciplinary actions:
**Some actions are not public record.*

1. Reprimand of the licensee
2. Put the licensee on probation under a variety of terms
3. Limit/Restrict the practitioner's license (limit the types of procedures that the licensee can perform)
4. Suspend the license
5. Permanently revoke the license
6. Warning letter

The Board does not have authority to order a licensee to refund fees paid by a complainant or pay restitution or monetary damages to a complainant.

The Board has no jurisdiction over the following:

1. Billing or fee disputes (i.e., the amount a dentist charges for services)
2. Insurance Coverage
3. Personality conflicts
4. Bedside manner or rudeness of practitioners (such as the dentist or his/her office staff's attitude or professionalism)
5. HIPAA Violations (This falls under the jurisdiction of the Federal Government.)
6. Scheduling Issues
7. Employee/Employer disputes

The Ohio State Dental Board appreciates your willingness to provide information on a possible instance of a violation of the Dental Practice Act. You are providing a public service to the citizens of the state of Ohio through the filing of your complaint.

Please understand that the OSDB investigations and the records pertaining to these investigations are confidential by law. Consequently, the OSDB will not be able to provide you with (1) any information as to whether an active investigation will be opened regarding the matter you reported or (2) if an active investigation is opened, the status of that investigation.

There is a 15 day turn around for assigning cases to an investigator. Please be aware they are worked in the order in which they are received.

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Do Not Write In This Space

COMPLAINT REGISTERED AGAINST

NOTE: The Ohio State Dental Board does not have authority over dental groups, practices, clinics or offices. Therefore you must provide the full name - - first and last - - of the individual dentist, hygienist, or healthcare worker who is the subject of the complaint.

Dentist/Hygienist/Dental Healthcare Worker:

First Name: (REQUIRED) **Last Name:**

Office Name: Office Phone Number:

Office Address: City: State: Zip:

PERSON REGISTERING COMPLAINT*

First Name: **Last Name:**

Address: City: State: Zip:

Phone Number(s): Email:

(If other than person registering complaint) - Patient Information:

First Name: **Last Name:** **DOB:**

Relationship to patient:

Insurance Type:

NATURE OF COMPLAINT

- ❒ Crown & Bridge
- ❒ Dentures
- ❒ Failure to Release Records
- ❒ Fillings/Cavities
- ❒ Implants
- ❒ Inappropriate Physical Contact with a Patient
- ❒ Inappropriate Prescribing Medication
- ❒ Insurance/Billing
- ❒ Misdiagnosis of a Condition
- ❒ Oral Surgery
- ❒ Orthodontics
- ❒ Patient Abandonment
- ❒ Periodontal Treatment
- ❒ Root Canal
- ❒ Infection Control
- ❒ Impairment (Alcohol/Drug, Mental, Physical)
- ❒ Unnecessary Treatment
- ❒ Other:

***If you want to remain anonymous please still provide contact information in case we need additional details.**

COMPLAINT DETAILS

(Please use the back side of this form or additional pages if necessary)

WITNESS(S)

NOTE: This should be someone who can either provide relevant information pertaining to the nature of this complaint or was an eyewitness.

First Name: **Last Name:**

Phone number: Email:

SUBSEQUENT TREATING DENTIST(S)

NOTE: If the patient has been examined or treated by another dentist for this same complaint please provide the full names and addresses of the additional treating dentist(s).

First Name: (REQUIRED) **Last Name:**

Office Name: Phone Number:

Office Address: City: State: Zip:

DESIRED OUTCOME OF THIS COMPLAINT

PLEASE INDICATE ANY OTHER STATE BOARD OR AGENCY NOTIFIED OF THIS INCIDENT

Continue to next page, must sign and return release.

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RELEASE OF INFORMATION

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RELEASE OF INFORMATION

Note: This Release is required to investigate your complaint. Failure to complete this portion of the complaint form will delay the investigation process.

I, _____ do hereby authorize the release of information and/or
Parent/Guardian/Patient
original records concerning _____.
Patient's Name

Specifically which relate to medical/dental treatment rendered by any health care provider or facility, either at an office facility or any other hospital and/or health care treatment center or facility involving this complaint. I hereby authorize the release of information, the original record, or a color copy of the original records regarding any treatment rendered at any of the aforementioned locations by any practitioner, including, but not limited to: radiographs* (originals or scanned to electronic media), insurance claim forms, financial records (computer generated or otherwise), progress notes, treatment plan, photos, models, work authorization forms, prescriptions, correspondence and any other documents related to or involving your care and treatment of the named patient.

***Radiographs: Digital x-ray records must be submitted in JPEG file format. Files in a proprietary file format or in a quality/resolution not sufficient for review may not be accepted. Each file should indicate when the X-ray was taken.**

I authorize the release of information and/or records to the Ohio State Dental Board or its authorized representative. I release any person, institution, organization, company or hospital from any liability as a result of providing the above-stated information and/or records to the Ohio State Dental Board. I further authorize the use of a copy of this release for use in obtaining the above-stated information and/or records.

_____ _____ _____

Signature **Date** **Patient DOB**