CALIFORNIA DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES AND HOUSING AGENCY • GAVIN NEWSOM, GOVERNOR

DENTAL BOARD OF CALIFORNIA
2005 Evergreen St., Suite 1550, Sacramento, CA 95815
P (916) 263-2300 | F (916) 263-2140 | www.dbc.ca.gov

CONSUMER COMPLAINT FORM

NOTE: The Dental Board of California (Board) does not have jurisdiction to investigate or enforce general (administrative) dental office procedures, fee and billing disputes, insurance coverage disputes, reimbursements or financial compensation, or rude behavior by dentists and dental staff. The Board may transmit any valid complaint to the local, state, or federal agency whose authority provides the most effective means to secure relief for the consumer. For more information regarding complaints and jurisdiction, please visit the Consumers webpage at https://www.dbc.ca.gov/consumers/index.html.

SUBJECT OF COMPLAINT

Last Name	First Name	Middle Initial	License No. (if known)
Name of Dental Office			
Street Address			
City	State	Zip Code	
Telephone No.	Email Address:		

PERSON SUBMITTING COMPLAINT: Please provide your contact information.

Last Name	First Name	Middle Initial
Street Address		
City	State	Zip Code
Telephone No.	Email Address:	

PATIENT INFORMATION

Last Name	First Name	Middle Initial	Date of Birth
Your Relationship to the Patient			
Has the patient been treated by another dentist for the same dental issue? If YES, provide **Supplemental Complaint Information** on page 3.			☐ YES ☐ NO
Is the patient a minor child?			☐ YES ☐ NO
• If NO, do you have the legal authority to act on the patient's behalf?			☐ YES ☐ NO
• If YES, attach documentation with proof that you have legal authority.			

DETAILS OF COMPLAINT – State your complaint in detail. Be as specific as possible. Explain what happened in the order that it happened. Please include dates of treatment and list all relevant treating providers specific to your complaint. Any supporting documents pertaining to your complaint should be submitted with this form. Documents may include photographs, invoices, and correspondence. Attach additional pages if necessary.

Incident Date:

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SUPPLEMENTAL COMPLAINT INFORMATION

Please provide the name, address, telephone number, and email address of any other dentists you have seen since you were treated by the subject of your complaint. Please also provide the date of the visit(s) to the other dentist(s).

Dentist 1

Name
Address
Email Address
Telephone No.
Date of Visit(s)

Dentist 2

Name
Address
Email Address
Telephone No.
Date of Visit(s)

Dentist 3

Name
Address
Email Address
Telephone No.
Date of Visit(s)

Please attach additional pages as necessary.

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Authorization for Release of Dental/Medical Patient Records

Patient Name	Date of Birth	
Check all Record Types that Apply: ☐ Dental Records ☐ Medical Records ☐ Diagnostic Images	☐ HIV/AIDS ☐ Psychiatric ☐ Alcohol/Drug Abuse	
Date of Death (if applicable)	Medical Record No. (if known)	Control No. (if applicable)

I, the undersigned, hereby 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 those records to the Dental Board of California (Board) or any Board representatives, related local, state, and federal governmental agencies, including but not limited to, investigators and legal staff.

This authorization shall remain valid for one year from the date of signature unless a different expiration date is specified. The Board prefers authorization to be valid for a period of three years: _____ (insert date).

I understand that I have the right to revoke this authorization by sending written notification to the Board at the above address. My written revocation will be effective upon receipt by the Board but will not be effective to the extent that such persons have acted in reliance upon this Authorization.

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 also understand that the subject of my complaint (the dentist or dental auxiliary I am complaining about) may receive a summary of my complaint and records pursuant to the Administrative Procedures Act (Gov. Code, § 11370 et seq.), the Information Practices Act (Civ. Code, § 1798 et seq.), and Business and Professions Code section 800, subdivision (c).

A copy of this Authorization shall be as valid as the original.

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

Name of Patient/Legal Representative	
Signature	Date

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

NOTE: A licensee or health care facility that fails or refuses to comply with a request for dental records of a patient that is accompanied by that patient's written authorization, within 15 days of receiving the request, shall pay a civil penalty to the Board pursuant to Business and Professions Code section 1684.1, subdivision (a). This authorization for the release of medical information complies with the requirements of Civil Code section 56.11.

NOTICE ON COLLECTION OF PERSONAL INFORMATION

Collection and Use of Personal Information
The Department of Consumer Affairs (DCA) and the Dental Board of California (Board) collects the information requested on this form as authorized by Business and Professions Code sections 325 and 326, Civil Code section 56.11, and the Information Practices Act (Civil Code section 1798 and following). The Board uses this information to follow up on your complaint in accordance with DCA's **Privacy Policy**.

Providing Personal Information is Voluntary
You do not have to provide the personal information requested. If you do not wish to provide personal information, such as your name, home address, or home telephone number, you may remain anonymous. In that case, however, the Board may not be able to contact you or help you resolve your complaint.

Access to Your Information
You may review the records maintained by the Board that contain your personal information, as permitted by the Information Practices Act. See below for contact information.

Possible Disclosure of Personal Information
The Board makes every effort to protect the personal information you provide. However, to follow up on your complaint, the Board may need to share the information you provided with the licensee you complained about or with other government agencies. This may include sharing any personal information you provided.

The information you provide may also be disclosed in the following circumstances:

- In response to a California Public Records Act request (Government Code section 7920.000 and following), as allowed by the Information Practices Act.
- Disclosure to another government agency as required by state or federal law.
- In response to a court or administrative order, a subpoena, or a search warrant.

Contact Information
For questions about this notice or for access to your records, contact the Complaint and Compliance Unit by email at DentalBoardComplaints@dca.ca.gov, by telephone at (916) 263-2300, or by mail at Attention: Complaint and Compliance Unit, Dental Board of California, 2005 Evergreen Street, Suite 1550, Sacramento CA 95815. For questions about DCA's Privacy Policy, contact the Department of Consumer Affairs at 1625 North Market Boulevard, Sacramento, CA 95834, by phone at (800) 952-5210, or by email at **dca@dca.ca.gov**.