



**WEST VIRGINIA BOARD OF DENTISTRY**  
PO Box 1447  
Crab Orchard, WV 25827  
PHONE: (304) 252-8266 TOLL FREE (877)914-8266  
FAX: (304) 253-9454  
[wvbde@suddenlinkmail.com](mailto:wvbde@suddenlinkmail.com)

**COMPLAINT FORM**

Name of Dentist or Dental Hygienist: \_\_\_\_\_

Address: \_\_\_\_\_ Email: \_\_\_\_\_

Name of person filing complaint: \_\_\_\_\_

Address: \_\_\_\_\_

Daytime Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

Patient's first and last name if other than person filing complaint:  
\_\_\_\_\_

Patient's Date of Birth: \_\_\_\_\_

Relationship to Patient:     Self     Parent     Son/Daughter     Spouse  
    Other \_\_\_\_\_

Date of Treatment: \_\_\_\_\_

**PLEASE NOTE:**

The West Virginia Board of Dentistry regulates the practice of dentistry and dental hygiene in West Virginia. The Board can discipline a licensed dentist or dental hygienist who violates the law or deviates from the standard of care for dentistry. **The Board has no jurisdiction over billing or fee disputes, insurance coverage, personality conflicts, HIPAA violations, scheduling issues, or employee/employer disputes.**

In order to ensure procedural due process, this complaint will be shared with the dentist or dental hygienist for his or her response. **ONCE COMPLETED, YOUR SIGNED COMPLAINT IS A MATTER OF PUBLIC RECORD.**



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**PLEASE LIST ANY PRIOR AND/OR SUBSEQUENT TREATING PRACTITIONERS  
RELATIVE TO YOUR COMPLAINT.**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_

Prior treating    Subsequent

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_

Prior treating    Subsequent

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_

Prior treating    Subsequent

By signing this complaint form, I hereby certify that the information provided is complete and true to the best of my knowledge. Further, I will voluntarily appear and testify to the facts in this complaint if called upon by the West Virginia Board of Dentistry.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_  
Patient or Legal Guardian

**Please sign the release on the next page and return with your complaint form. Failure to sign and return the release may result in a delay of the investigation of your complaint.**

<b>FOR OFFICE USE ONLY</b>	
Complaint No.: _____	Date Received: _____
License No.: _____	Receipt Letter Sent: _____
Licensee Letter Sent: _____	Violation: _____
Disposition: _____	Disposition Date: _____



**WEST VIRGINIA BOARD OF DENTISTRY**

**RELEASE OF DENTAL/MEDICAL RECORDS**  
**FROM DENTAL/MEDICAL PROVIDERS OR FACILITIES**

I hereby authorize and direct release to the West Virginia Board of Dentistry or its agents all records and information, including billing information, x-rays and models of any treatment and/or consultation of:

NAME OF PATIENT: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

as may be requested by the Board or its agent. A copy of my signature on this release shall be authorization and direction to release such records and information as appropriate to the investigation of the complaint. My healthcare records are **not** public record and are requested solely for the purpose of the investigation of the complaint. Only individuals directly involved in the complaint process will have access to these records. A photo copy of this authorization shall be deemed as effective as an original.

Date: \_\_\_\_\_

Signature: \_\_\_\_\_  
Patient or Legal Guardian of Patient

**THIS AUTHORIZATION SHALL BE EFFECTIVE FOR ONE YEAR FROM THE DATE OF SIGNING.**