Nevada State Board of Dental Examiners

2651 N Green Valley Parkway, Ste.104 • Henderson, NV 89014 • (702) 486-7044 • (800) DDS-EXAM • Fax (702) 486-7046

COMPLAINT FORM

Pursuant to NRS 631.360, the Board is required upon receipt of a verified complaint in writing from any person setting forth facts which, if proven, would constitute grounds for initiating disciplinary action, investigate the actions of any person who practices dentistry or dental hygiene in the state of Nevada.

The Nevada State Board of Dental Examiners does not investigate standard of care issues for dental treatment(s) that was performed five years ago or longer.

Complainant Name: _____

Address: _____

_____

_____

Phone Number: _____

Email address: _____

Dentist or Dental Hygienist First/Last Name: _____

Practice Address: _____

_____

_____

Phone Number: _____

Name of any subsequent treating dentist or second opinion dentist:

_____

Note: The Board does not have jurisdiction over office personnel of a dental practice

What date(s) was the treatment in question performed?

_____ _____ _____

Provide a **<u>detailed summary</u>** of the allegations. Please add additional sheets as needed to explain the present situation:

If you have documents relevant to the allegations contained in your complaint, please attach copies of the documents with this complaint form.

Note: Please complete the Verification Form and return along with the Complaint Form.

Note: Please complete the Authorization to Release Records Form and return the Authorization to Release Records Form along with the Complaint Form.

Print Name: _____

Signature: _____

Date: _____

Once the Nevada State Board of Dental Examiners has received the Complaint Form, Verification Form, and the Authorization to Release Records Form, the Board will notice the complaint to the licensed dentist or dental hygienist. Thereafter, upon receipt of the written response and copy of the dental records filed by the dentist or dental hygienist, the investigative file will be assigned to a clinical reviewer who will review the case and prepare a report. Thereafter, the case will then move on to the NRS 631.3635 Review Panel for their review and consideration. The NRS 631.3635 Review Panel will then provide the Board with recommendations for action.

Please be advised, the General Counsel for the Board is the attorney for the Board Members and Staff, the General Counsel does not represent you or the licensee being investigated. Filing this complaint does not toll the statute of limitation period required for filing a civil complaint or claim of malpractice.

Mail, fax, or email the completed Complaint Form, Verification Form, and Authorization to Release Records Form to:

Nevada State Board of Dental Examiners
2651 N Green Valley Pkwy, Ste 104
Henderson, Nevada 89014
Fax No: 702.468.7046
E-mail: nsbde@dental.nv.gov

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VERIFICATION OF COMPLAINT

STATE OF _____

COUNTY OF _____

Regarding the complaint submitted to the Nevada State Board of Dental Examiners against

_____, _____, first duly sworn, deposes and says:
Dentist's or Hygienist's First and Last Name Complainant's Name

1) That he/she is the Complainant in the aforementioned action;

2) That he/she has read the foregoing statements/complaint to which this verification applies and knows the contents thereof;

3) That the same is true and correct to his/her own knowledge and belief;

4) That if called upon to testify regarding the statements made in the attached complainant's complaint, he/she could do so competently;

5) That he/she will keep and maintain confidential the Dentist's and/or Dental Hygienist's answer/response to the complainant's complaint and will not use any documents and/or information, if any, received from the Board regarding Dentist's and/or Dental Hygienist's answer/response to the complainant's complaint in any civil action or lawsuit (this includes, but is not limited to disclosing, seeking to have admitted into evidence, or producing in discovery, providing to expert witnesses, etc.);

6) That he/she understands that the investigation into his/her complaint, including the complaint itself, is confidential;

7) That he/she will keep and maintain the confidentiality of the complaint and any documents and information, if any, received from the Board regarding the Board's investigation into his/her complaint, and will instruct his/her agents and representatives to also maintain said confidentiality;

8) That he/she understands and agrees that complainant's or his/her representative or agent's public dissemination or other failure to maintain the confidentiality of the complaint and/or any documents received concerning the investigation into the complaint may result in the dismissal of complainant's complaint.

9) By signing this form, I affirm that each document is complete and correct and that all information contained in this submission is true under the pains and penalties of perjury and the requirements of NRS Chapter 631 and NAC Chapter 631 and Nevada law generally. I also acknowledge that if I have directed or authorized a person to complete or submit this information on my behalf, I, the Complainant, am fully responsible for the content of the submission.

_____
Signature of Complainant

_____
Address

_____
City, State, Zip

_____
Telephone Number

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AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

To Whom It May Concern:

I,_____, do hereby authorize and direct you to furnish to the NEVADA STATE BOARD OF DENTAL EXAMINERS, any and all medical and/or dental records pertaining to me, for any and all dates of treatment, including but not limited to:

Any and all medical and dental records; consultation reports; records of treatment; office notes; treatment plans; dentists' notes; clinical notes; hygienists' notes; periodontal charts; informed consents; medication agreements; prescription information; intake forms; histories; diagnoses; prognoses; documentation of telephonic discussions and/or messages; correspondence; consultation reports; referrals; lab requests; lab reports; drawings or sketches (computer generated, hand-drawn or other); risk assessments; hospital records; test results and reports; information pertaining to drug and/or alcohol treatment; all x-ray films and reports; MRI scans and reports; CT scans and reports; any and all diagnostic imaging films, tests and their associated reports taken by you or contained in your files; any and all bills, invoices, ledgers and statements reflecting all charges and payment history including benefit payments and/ or patient payments, patient co-payments or deductibles, adjustments, write-offs or discounts; any liens filed including amount of lien; any charges turned over to collection/collection agency, including amount and name of collection agency; any and all documents contained in the patient's electronic or paper chart.

I authorize the **NEVADA STATE BOARD OF DENTAL EXAMINERS** to obtain the above records on my behalf, I authorize the **NEVADA STATE BOARD OF DENTAL EXAMINERS** to use the above records in any investigation and/or public hearing conducted by the **NEVADA STATE BOARD OF DENTAL EXAMINERS**, its attorney or any agent, representative, investigator or expert thereof. This release authorizes the **NEVADA STATE BOARD OF DENTAL EXAMINERS** its attorney or any representative, agent, investigator or expert thereof. to see or copy or utilize the above records regarding the patient's condition, treatment and any and all information or opinions pertaining thereto.

I understand that I may revoke this authorization to the extent allowed by law but understand prior to the provider's receipt of a revocation, the provider is not prohibited from the release of information in reliance on my original authorization. I understand that once my health information is released pursuant to this authorization, the **NEVADA STATE BOARD OF DENTAL EXAMINERS** may re-disclose it as required or necessary pursuant to Federal or State law.

A copy of this authorization is as valid as an original and shall have the same force and effect as the original.

Dated this _____ day of _____, 20____.

_____
Signature of Patient or authorized Representative/Guardian

_____
Date of Birth

_____
Address

_____
City, State, Zip

_____
Telephone Number