



UNIFORM COMPLAINT FORM

Missouri Statutes 575.060 — False Declarations, Whoever knowingly makes a false statement in writing with the intent to mislead a public servant in the performance of his official duty may be guilty of a Class B misdemeanor.

IMPORTANT, PLEASE READ: The Missouri Dental Board is charged with the regulation of the dental profession in Missouri. The Board only has authority to discipline the professional license of those persons licensed by the Board. **The Board does not have the authority to order a licensee to refund fees paid by a complainant or pay restitution or monetary damages to a complainant.**

Please complete this form and return to: Missouri Dental Board, 3605 Missouri Boulevard, P.O. Box 1367, Jefferson City, Missouri 65102-1367.

COMPLAINANT INFORMATION

COMPLAINANT NAME (FIRST, MIDDLE, LAST, SUFFIX)		
PATIENT NAME (IF OTHER THAN COMPLAINANT)		
PATIENT'S SSN	PATIENT'S DATE OF BIRTH	
COMPLAINANT'S ADDRESS		
CITY	STATE	ZIP CODE
COMPLAINANT'S TELEPHONE NOS: HOME	BUSINESS	
COMPLAINANT'S E-MAIL ADDRESS		

SUBJECT OF COMPLAINT

NAME OF DENTIST	TELEPHONE NO.	
NAME OF COMPANY		
ADDRESS		
CITY	STATE	ZIP CODE

DETAILS OF COMPLAINT

Please provide full details of your complaint. Please attach copies of all bills, documents, records, correspondence and contracts. If additional space is needed, attach additional pages.

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PREVIOUS OR SUBSEQUENT TREATING DENTISTS

Were you seen or treated by any other dentist(s) prior to and/or after treatment was rendered by the dentist referred to in your complaint? <i>If yes, please complete the information below for each dentist.</i>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
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NAME OF DENTIST	PRIOR <input type="checkbox"/>	AFTER <input type="checkbox"/>
ADDRESS		
APPROXIMATE DATE(S) IN WHICH YOU WERE SEEN BY THE ABOVE DENTIST:		

NAME OF DENTIST	PRIOR <input type="checkbox"/>	AFTER <input type="checkbox"/>
ADDRESS		
APPROXIMATE DATE(S) IN WHICH YOU WERE SEEN BY THE ABOVE DENTIST:		

NAME OF DENTIST	PRIOR <input type="checkbox"/>	AFTER <input type="checkbox"/>
ADDRESS		
APPROXIMATE DATE(S) IN WHICH YOU WERE SEEN BY THE ABOVE DENTIST:		

**NOTICE:
ALL COMPLAINTS MUST BE SIGNED.**

Such signature authorizes the Missouri Dental Board to release a copy of your complaint along with any attachments to the licensee who is the subject of the complaint.

Your signature also authorizes the Missouri Dental Board to collect your dental records from the licensee who is the subject of the complaint and any prior or subsequent treating dentists.

COMPLAINANT'S SIGNATURE	DATE
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Are there additional pages attached?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
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