



**DIVISION OF MEDICAL QUALITY ASSURANCE
Consumer and Investigative Services**

Health care practitioners are regulated by the Department of Health and the action which may be taken is administrative in nature, e.g., reprimand, fine, restriction of practice, remedial education, administrative cost, probation, license suspension or license revocation. The Department cannot represent you in civil matters to recover fees paid or seek remedies for injuries. You may wish to consult a private attorney regarding these matters.

COMPLAINT FORM INSTRUCTIONS

The Department of Health investigates complaints and reports involving health care practitioners and enforces appropriate Florida Statutes.

ISSUES WHICH ARE NOT WITHIN THE AUTHORITY OF THE DEPARTMENT INCLUDE:

- * **Fee disputes** (i.e. broken or missed appointments)
- * **Billing disputes** (i.e., the amount a physician charges for services).
- * **Personality conflicts**
- * **Bedside manner or rudeness of practitioners** (such as the physician or his/her office staff's attitude or professionalism)

HOW TO FILE A COMPLAINT/REPORT AGAINST A HEALTH CARE PRACTITIONER:

- To file a complaint/report, you must do so in a signed, written report. For your convenience you may use this form providing dates and details about your complaint.
- Use a separate complaint form for each practitioner you wish to file a complaint against.
- Be specific and include copies of pertinent medical records, correspondence, contracts, and any other documents that will help support your complaint.
- Medical records are needed to process your complaint. Since a health care practitioner cannot disclose his or her patient names or records with authorization, the Authorization for Release of Patient Information form included on page 3 must be completed and signed. **Signatures must be witnessed or notarized.**
- The Department will acknowledge receipt of your complaint or report by letter.
- If the allegations contained in your complaint/report are determined to be possible violations of applicable laws and rules, your complaint will be opened for investigation.
- Please note that if your complaint is assigned for investigation, a copy of the complaint form will be provided to the health care practitioner pursuant to Florida law.
- The Department may investigate an anonymous complaint if the complaint is in writing and is legally sufficient, if the alleged violation of law or rules is substantial, and if the department has reason to believe, after preliminary inquiry, that the violations alleged in the complaint are true.

If you have questions about the complaint process, contact the Consumer Services Call Center in Florida toll free at 1 (888) 419-3456, or the Consumer Services Unit at (850) 245-4339.



HEALTHCARE PRACTITIONER COMPLAINT FORM

COMPLAINANT/REPORTER

Your Name: _____
Last First M.I.

Address: _____
Street Address Apartment/Unit #

_____ *City State ZIP Code*

Home Telephone: () _____ Work Telephone: () _____ Best Time to Call: _____

SUBJECT OF COMPLAINT/REPORT

HEALTHCARE PRACTITIONER INFORMATION

Provider's Name: _____
Last First M.I.

Practice Address: _____
Street Address Apartment/Unit #

_____ *City State ZIP Code*

Home Telephone: () _____ Work Telephone: () _____

Profession: _____ (i.e. doctor, dentist, nurse, etc.)

License Number: _____ (if known)

PATIENT INFORMATION

(Complete this section if Patient is not the same as Complainant/Reporter)

Name of Patient: _____
Last First M.I.

Address: _____
Street Address Apartment/Unit #

_____ *City State ZIP Code*

Home Telephone: () _____ Work Telephone: () _____

YOUR RELATIONSHIP TO PATIENT

- Self Parent Son/Daughter Spouse Brother/Sister Friend Other Practitioner

*** Legal Guardian/provide court documents Other _____

NATURE OF COMPLAINT/REPORT

(Please check all that apply.)

- | | | |
|--|--|---|
| <input type="checkbox"/> Quality of care | <input type="checkbox"/> Inappropriate prescribing | <input type="checkbox"/> Excessive test or treatment |
| <input type="checkbox"/> Misdiagnosis of condition | <input type="checkbox"/> Sexual contact with patient | <input type="checkbox"/> Failure to release patient records |
| <input type="checkbox"/> Substance abuse | <input type="checkbox"/> Insurance fraud | <input type="checkbox"/> Impairment/medical condition |
| <input type="checkbox"/> Advertising violation | <input type="checkbox"/> Misfilled prescription | <input type="checkbox"/> Patient abandonment/neglect |

Unlicensed Problem other than listed above _____

Have you attempted to contact the practitioner concerning your complaint? Yes Date: _____ No

Would you be willing to testify if this matter goes to a formal hearing? Yes No

If the incident involved criminal conduct, you should contact your local law enforcement authority. Have you contacted your local law enforcement authority? Yes No

If yes, state the name of the person or office that you contacted. _____ When did you make this contact? _____ Please give case number if available. _____

***NOTE: If other than patient or parent of a minor patient, please provide documentation indicating appointment of Legal Authority/Guardianship or Personal Representative.

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

Full Name:	Address:	Telephone Number:
_____	_____	_____
_____	_____	<input type="checkbox"/> Prior Treating <input type="checkbox"/> Subsequent Treating
Full Name:	Address:	Telephone Number:
_____	_____	_____
_____	_____	<input type="checkbox"/> Prior Treating <input type="checkbox"/> Subsequent Treating
Full Name:	Address:	Telephone Number:
_____	_____	_____
_____	_____	<input type="checkbox"/> Prior Treating <input type="checkbox"/> Subsequent Treating

WITNESSES (PLEASE GIVE FULL NAME, ADDRESS AND TELEPHONE NUMBER)

Full Name:	Address:	Telephone Number:
_____	_____	_____
_____	_____	_____
Full Name:	Address:	Telephone Number:
_____	_____	_____
_____	_____	_____
Full Name:	Address:	Telephone Number:
_____	_____	_____
_____	_____	_____

Please give full details of your complaint/report: include facts, details, dates, locations, etc. Please attach copies of medical records, correspondence, contracts, and any other documents that will help support your complaint. (attach additional sheets if necessary).

I have attached copies of medical records, correspondence, contracts, and any other documents that will help support your complaint.

WHAT WOULD SATISFY YOUR COMPLAINT?

Florida Statutes 837.06, False Official Statements: Whoever knowingly makes a false statement in writing with the intent to mislead a public servant in the performance of his official duty shall be guilty of a misdemeanor of the second degree.

Signature: _____ Date: _____
(Required to file complaint)



**Please mail this form to:
Florida Department of Health
Consumer Services Unit
4052 Bald Cypress Way, Bin C-75
Tallahassee, Florida 32399-3275**



DENTAL QUESTIONNAIRE

PART A

COMPLAINANT: _____

SUBJECT: _____

1. Has the treatment provided by the dentist been altered? If so by whom?

2. Please provide the following:

(a) Sign and date the enclosed Authorization for Release of Medical Information form. Please have your signature notarized or witnessed, and return the form to this office;

(b) PATIENT RECORDS FROM THE DENTIST;

(c) Name, address, and telephone number of any previous dentist(s);
PLEASE INCLUDE PATIENT RECORDS

1. Has the treatment provided by the dentist been altered? Yes/No

(d) Name, address, and telephone number of subsequent dentist(s), including current dentist;

PLEASE INCLUDE PATIENT RECORDS

(e) Factual narrative from subsequent dentist(s) as to his/her clinical observation, treatment plan, and treatment provided to date;

(f) All x-rays; (from subject, previous and subsequent dentists)

(g) Chronology of your treatment rendered, including month, day and year of treatment;

(h) Detailed description of the treatment provided and the major complaint; (please use the attached chart)

PLEASE BE ADVISED THAT THE DEPARTMENT HAS NO AUTHORITY TO MANDATE A LICENSEE TO PROVIDE A REFUND. THESE MATTERS ARE CIVIL IN NATURE AND SHOULD BE ADDRESSED TO THE COURT WITH THE APPROPRIATE JURISDICTION.



DENTAL QUESTIONNAIRE

PART B **COMPLAINANT:** _____

SUBJECT: _____

DENTURES

1. Was treatment provided by a general dentist or a prosthodontist?

2. Have you previously worn denture: Yes/No
If so, how long did you wear the dentures? _____
3. If you have previously worn dentures, what type are they?

4. Are you currently wearing the dentures in issue? Yes/No
 - a) Are they: _____ upper _____ lower
 (a) full _____ (a) full _____
 (b) partial _____ (b) partial _____
 - b) If no, where are the dentures in issue? _____
5. Have the dentures been relined? Yes/No
If yes, by whom?

6. Have the dentures been altered? Yes/No
If yes, by whom?

7. If you answered NO to question number 4, are you currently wearing any dentures? Yes/No
 - a) Are they: _____ upper _____ lower
 (a) full _____ (a) full _____
 (b) partial _____ (b) partial _____
 - b) Who provided these dentures? _____
8. What is your major complaint regarding these dentures? (i.e. too loose, too tight, causes sore spots, etc.)

9. Has the dentist made any effort to resolve your complaints? Include the dates that adjustments or consultations occurred.



DENTAL QUESTIONNAIRE

PART C **COMPLAINANT:** _____

SUBJECT: _____

CROWN & BRIDGE

1. Was treatment provided by a general dentist or a prosthodontist?

2. Please indicate, on the enclosed chart, which tooth/teeth are involved

3. What is your major complaint?

4. What type of crown did you expect to receive? (porcelaine, acrylic, etc.)

5. Are you satisfied with the appearance? Yes/No
If not, explain why

6. Have you experienced problems with:

_____ pain	_____ uneven bite
_____ constant need for recementing	_____ recurrent decay
_____ cracking, chipping or breakage	_____ looseness
_____ rough surfaces	
_____ other _____	
7. Were you advised that the crown and/or bridge in questions was substandard?
If so, by whom?



DENTAL QUESTIONNAIRE

PART D **COMPLAINANT:** _____

SUBJECT: _____

ROOT CANAL THERAPY

1. Was treatment provided by a general dentist or an endodontist?

2. Please indicate, on the chart provided, the tooth/teeth treated.
3. Was an x-ray available for diagnosis? Yes/No
If so, which dental office provided the x-ray? _____
When was the x-ray taken? _____
4. Were any x-rays taken by the subject's office before, during or after completion of the Root Canal Therapy?
If so when? _____
5. Was a rubber dam used? Yes/No
6. Was the Root Canal Therapy completed by subject? Yes/No
If not by whom? _____
7. Were you advised of any necessary follow-up care? Yes/No
If so, what? _____
8. Did the dentist advise you of any complications after the treatment? Yes/No
9. What is your major complaint with the Root Canal Therapy?

10. Were you advised that the Root Canal Therapy in question was substandard? Yes/No
If so, by whom? _____

