COMPLAINT FORM
KENTUCKY BOARD OF DENTISTRY

Person Filing Complaint

Name _____

Address _____ City _____State __ Zip_____

Day Telephone (__)_____ Evening Telephone (_____) _____

Patient's Date of Birth_____/_____/_____

Patient Information (if different from above)

Name _____

Address _____ _____City _____ State._____ Zip_____

Relation _____

The specific name of the Individual Dentist/Hygienist/Assistant/Other Person must be provided in order for a complaint to be generated by the Kentucky Board of Dentistry.

(The name of the dental practice *will not* suffice to open a complaint)

Name _____

Address _____ City____ State___Zip____

Telephone () _____

Names and phone numbers of person who may provide additional information

_____

_____

_____

_____

_____

Brief description of offense; include date, time, dental professional and location.

_____

_____

_____

_____

_____

_____

_____

Revised 1/10/2017

By signing this complaint form, I hereby certify that the information provided is complete and true to the best of my knowledge.

Signature _____ Date _____
(patient or guardian)

Send to: Kentucky Board of Dentistry
312 Whittington Parkway, Suite 101
Louisville, Kentucky 40222
Fax: 502/429-7282

Revised 1/10/2017

BOARD OF DENTISTRY

Steven L. Beshear
Governor

312 Whittington Parkway, Suite 101
Louisville, Kentucky 40222
Phone: (502) 429-7280
Fax: (502) 429-7282
http://dentistry.ky.gov

David J. Beyer
Executive Director

Authorization for Release of Medical and Dental Records to the Kentucky Board of Dentistry

I, _____ the undersigned, hereby authorize the
print full name

full release of any and all medical and dental records, billing information, and medical and dental reports from the dentist, physician, or other medical personnel, or any licensed health care facility, regarding the medical and dental history, diagnosis, and treatment relevant to my initiating complaint, filed with the Board against

_____, to the Executive Director of the Kentucky
name of dentist or dental hygienist

Board of Dentistry or any authorized agent or investigator of the Board.

The Board's address is: 312 Whittington Pkwy, Suite 101, Louisville, Kentucky 40222. Copies of such documents may be mailed to the Executive Director at this address or hand-delivered to any authorized agent or investigator or the Board.

A photocopy of this authorization shall be deemed as effective as an original. This authorization shall be effective for one year from the date of signing.

_____ _____
Date Signature of patient or legal guardian of patient