

**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 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.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_





## BOARD OF DENTISTRY

**Andy Beshear**  
Governor

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

**Jeff Allen**  
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