Kentucky Board of Dentistry

312 Whittington Parkway, Ste. 101, Louisville, KY 40222
(p) 502-429-7280 | (f) 502-429-7282 | kbd@ky.gov | dentistry. ky.gov

COMPLAINT FORM

Before making a complaint, please review the Complaints and Investigations FAQs and/or KRS 313.090. When you are ready to file your complaint, please submit this form, the Medical and Dental Records Release, and any other supporting documents to the contact information above. After receiving the complaint, a compliance specialist will contact you.

Section 1. Complainant Information (person making the complaint)

Name _____

Address _____ City _____ State _____ Zip _____

Phone _____ Email _____ Patient DOB _____

Are you the patient? If not, what is the patient name and/or your basis for the complaint? _____

Section 2. Licensee Information (complaints must be filed against a specific person, not just a business)

Name _____ Business _____

Address _____ City _____ State _____ Zip _____

Section 3. Complaint Description

Please provide a thorough description of the offense, including dates, locations, witness information and other relevant details. If you need more space to fully describe your complaint, you may include additional pages with this form.

Section 4. Affirm and Sign

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

Complainant's Signature _____ Date _____

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COMPLAINT DESCRIPTION (CONT.)

If necessary, use this form to continue your complaint. You may submit as many pages as needed. Please initial each page.

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Medical and Dental Records Release Authorization

I, _____ the undersigned, hereby authorize the full release of any
print full name

and all medical and dental records, billing information, and 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 of Dentistry against

_____, to the executive director of the Board or any authorized
name of dentist or hygienist

agent or investigator of the Board.

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

Signature of patient or guardian _____ Date _____