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

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

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Revised 1/13/2017

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 1/13/2017

BOARD OF DENTISTRY

Matthew G. Bevin
Governor

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

William L. Brown
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