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.

____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

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
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

Revised 1/13/2017