Kansas Dental Board

COMPLAINT FORM

To file a complaint, please state clearly and specifically all allegations against the person named below. **List each incident, specific date(s), and a brief statement describing each incident. List additional treating dentist(s) if needed.** If additional space is required, please attach additional pages. Attach copies of any documents you have concerning the allegation. **Please be aware that the licensee in question may be entitled to a copy of your complaint. Also the Kansas Dental Board CANNOT help with recouping any money or financial disputes.**

PERSON AGAINST WHOM THE ALLEGATION IS MADE:

Name _____ Indicate - Dentist or Dental Hygienist

Address _____

Street City Zip

PLEASE TYPE OR PRINT CLEARLY. **USE ADDITIONAL PAGES IF NECESSARY**

Print Name: _____ **Signed:** _____

KANSAS DENTAL BOARD
Landon State Office Building
900 SW Jackson, Suite 455-S
Topeka, KS 66612
Phone: 785-296-6400 Fax: 785-296-3116
info@dental.ks.gov

RELEASE OF INFORMATION AUTHORIZATION

I hereby authorize the release of information and/or original records concerning the below listed patient, specifically which relate to medical/dental treatment rendered by any health care provider or facility. I hereby authorize the release of information, the original record, or a copy of the original records regarding any treatment rendered at any of the aforementioned locations by any practitioner, including, but not limited to: radiographs (originals or scanned to a CD), insurance claim forms, financial records, progress notes, treatment plan, photos, models, work authorization forms, prescriptions, correspondence, and any other documents related to or involving your care and treatment of the named patient.

I authorize the release of information and/or records to the Kansas Dental Board or its authorized representative. I release any person, institution, organization, company or hospital from any liability as a result of providing the above-stated information and/or records to the Kansas Dental Board. I further authorize the use of a copy of this release for use in obtaining the above-stated information and/or records.

Type or Print Patient Name

Date of birth

Patient Signature

Parent/Guardian Signature (if applicable)

Patient Address

Street **City** **State** **KS**

Patient phone number

Date