

PATIENT COMPLAINT FORM

Please state your first and	last name:		
Address:		Phone:	
	YesNo. If no,	please state the patient's full name a	and your relation
Nature of Complaint (Pleas			
Names of Clear Lakes Der	ntal team member(s)	involved or description:	
complaint. I will provide an	y and all information	e headquarters of Clear Lakes Denta and cooperate in helping the headqu of my knowledge, this information is	arters of Clear
Signature of Patient	Date	Signature of Complainant (If different from patient)	Date