PATIENT COMPLAINT FORM

Instructions: *Please print this form and fill out in its entirety (do not forget to sign). Email the completed form to info@clearlakesdental.com to be processed. A member of our team will get in touch with you. Thank you.*

Location Information:

Please provide the information of the clinic you would like to file this complaint for:

Address:_____

City:_____ State:_____ Zip:_____

Patient information:

First Name:_____ Last Name:_____ Date of Birth:_____

Address:_____Phone:_____

Are you the patient? _____Yes _____No

If no, please state your relation to the patient: _____

Please state your first and last name: _____

Please list your phone number: _____

Nature of Complaint (Please limit to 100 words or less):

_____

_____

_____

_____

_____

_____

_____

Names of Clear Lakes Dental team member(s) involved or physical description:

_____

By signing this complaint form, I request that the headquarters of Clear Lakes Dental investigate my complaint. I will provide any and all information and cooperate in helping the headquarters of Clear Lakes Dental resolve my complaint. To the best of my knowledge, this information is true and accurate.

_____ _____

Signature of Patient Date

Signature of Complainant Date
(If different from patient)