Patient Concerns Form

Please fill out all information as completely as possible.

If we do not have your complete contact information, we cannot send you follow-up information.

Patient Information		Visit Information	
Patient chart # (if available)		**Date Complaint Submitted**	
Patient name		**Date of Complaint Occurrence**	
Address		**List all Department(s) Involved**	
City/State/ Zip code		**Name(s) of Staff Involved**	
Phone number			
Date of birth			

Please check the box(es) below that most accurately describe your concern(s) today:

Need Appointment		Pain Medication/ Pain Contract		Contract Health Services - Want Outside Referral or Appointment	
Telephone/ Return Calls & Messages		Customer Service/ Rude staff		Contract Health Services - Want Bills Paid	
Long Wait Time		Disliked Medical Treatment Received / Thinks Medical Treatment is Wrong		Contract Health Services - Transportation	
Need Medication Refills		Other:(*please explain*)			

Please describe your concern(s):

What action(s) would you like to see come out of this as a resolution? (check applicable)

- ☐ **Telephone call**
- ☐ **Acknowledgement of concern**
- ☐ **Management notified**
- ☐ **Appointment made**
- ☐ **Other (please explain)**

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