

Patient Grievance Form

Use this form to let us know about a complaint or concern ("grievance") you have about your experience.

Patient name:				
Date of birth: Today's date:				
Address:				
City:		St	ate:	Zip:
			sage for you at this nu	mber? □Yes □ No
Tell us about you	ur complaint/conce	ern:		
Location of incident	:			
_	☐ Call Center ☐ HIM/Referrals —		□ Dental□ Pediatrics	☐ Dutton ☐ Vista
Please he as specific as i	possible. Include dates, tin	nes staff names, and lo	cations. Use the other side	e of the form if needed.
What solution w	ould you like?			
Call Back Requeste	ed? □ Yes □ No			

This section to be used for internal use only:

Reviewed by (print name and title):	Date:	
Referred to:	Date:	
Resolution:		
Variance Completed? ☐ Yes ☐ Not needed	Patient Contacted? ☐ Yes ☐ No	
Returned to Site Director:	Date:	