Community Health Center of Southeast Kansas

PATIENT COMPLAINT FORM

Patient Name: _____ Date of Birth: _____ Phone Number: _____

Name of Person Completing Complaint Form (if different from patient): _____

Type of Visit: ___ Medical ___ Dental ___ Behavioral Health ___ Pharmacy

Date of Visit: _____

Description of Complaint: _____

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Complaint is continued on back or on attached page: ____ *Yes* ____ *No*

Signature of Person Completing Report: _____ Report Date: _____

CHC/SEK Supervisor Signature: _____ Date Received: _____

Risk Manager Signature: _____ Date Received: _____