AVANCE CARE, P.A.

Patient Complaint Form

Date: ______________________________

Person Registering Complain: ____

Address: ____

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Phone: ____ Alternate Phone: _____________________________________

Name of Patient: ____

Date of Birth: ____

In the event that we are not able to address your complaint in person, we ask that you write down your concern and it will be passed onto the office manager when she returns to the office. She will get in touch with you using the phone number(s) you provided above.

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Signature: ____

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For Office Use:

Resolution of Complain:

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By Whom: ____