9022 Culebra Rd., Suite 112
San Antonio, TX 78251

Patient Complaint Form

____ _____/_____/_________
Patient Name (Please print) Patient DOB

____ (_____)-_____-_______
Patient Address Patient Telephone #

____
Name of Person Completing Form if Not Patient (Please print)

Relationship to patient: ☐ Parent ☐ Legal Guardian ☐ Other:_________________________________

*Please describe your complaint in detail and include any pertinent information (names, dates, what occurred, etc.):

(*Please attach additional pages as needed.*)

If you could think of a fair resolution, what would that be? ___________________________________

____ ________________
Patient Signature (or Signature of Person Completing Form if Not Patient) Date

(If this complaint was taken by a staff member, check here: ☐)

_____________________ _________________________ ________________
Staff Member Name (Please print) Signature Title Date

For Physician or Staff Completion Only
Investigation, Follow-up, and Response:
____
____
____

Phone: 210-802-3777 Fax: 210-819-4555
info@WestoverHillsPrimaryCare.com www.WestoverHillsPrimaryCare.com