Sergio Cruz
Chair, Governing Board

www.coastalhw.org

Philip Keiser, MD
Executive Director

Patient Complaint Form

Customer Name: _____ **Date of Birth**: _____

Customer Address: _____ **Phone #**: _____

Appointment Type: _____ **Email:** _____

Date of Service: _____ **Provider Seen:** _____

Description of Complaint (Please be specific as possible):

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Desired Action:

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Customer Signature _____ Date_____ Staff_____ Date_____