420 Line Street/P.O. Box 400
New Madrid, MO 63869
573-748-2404

PATIENT COMPLAINT FORM

Name of Complainant _____

Name of Patient: _____

Address:_____ Phone:_____

Are you the patient? _____Yes _____No. If no, please state your relationship to the patient:
_____

Where did problem occur?:
[ ]New Madrid Medical [ ]New Madrid Dental [ ]Bernie Medical [ ]Bernie Dental
[ ]Sikeston Medical [ ]Sikeston Dental Clinic [ ]Portageville Clinic [ ]Kennett Medical
[ ]Kennett Dental Clinic [ ] Senath Medical [ ]Benton Medical [ ] Benton Dental

Nature of Complaint (Please limit to 100 words or less):_____
_____
_____
_____
_____

Names of Personnel Involved_____
_____
_____

Were there any witnesses? If so, please list their names and phone numbers._____
_____
_____

Did our staff attempt to correct the problem when it occurred? [ ]Yes [ ]No

By signing this complaint form, I request that Semo Health Network investigate my complaint. I will provide any and all information and cooperate in helping Semo Health Network resolve my complaint. To the best of my knowledge, this information is true and accurate.

_____ _____

Signature of Patient Date Signature of Complainant Date
(If different from patient)