Lake County Tribal Health

Patient Feedback Form

**indicates mandatory field*

Patient Name*: _____

Patient Parent/Guardian Name: _____ Patient Telephone*: _____

LOCATION*

- ◯ Lakeport Clinic
- ◯ Pain and Wellness Center
- ◯ Pediatrics
- ◯ Southshore Clinic
- ◯ Southshore Satellite Clinic

DEPARTMENT*

- ◯ Behavioral Health
- ◯ Dental
- ◯ Laboratory
- ◯ Medical
- ◯ Pediatrics
- ◯ Pharmacy
- ◯ Other

COMPLIMENT

COMPLAINT	
Date Occurred*:	Time Occurred*:
Complaint:	
Action you would like to see taken:	

Signature*: _____ Date*: _____

THANK YOU FOR TAKING THE TIME TO SHARE YOUR FEEDBACK ABOUT YOUR EXPERIENCE.

We are committed to providing care that honors and respects everyone who walks through our doors. Your input guides us in that mission and helps us ensure that every person receives the compassionate, quality care they deserve.