Patient Concerns Form

The University of Louisville School of Dentistry strives to provide quality work and service in an environment that promotes respect for all.

Patients have the right to express concerns or complaints with assurance that the submission of a concern will not compromise the quality of care or future access to care. In order to address any concerns that you may have, please complete this form.

Name:	Date:
Telephone No.:	Date of Birth:

My Concern is:

All patient concerns must be submitted in writing for review. Please return to the following address:

University of Louisville School of Dentistry
ATTN: Quality Assurance Staff
Office of Clinical Affairs
501 S. Preston St., Suite 264
Louisville, KY 40202

To protect your privacy, please mark your envelope: "CONFIDENTIAL HIPAA Protected Information for Addressee Only"
Patient concerns are addressed by the Quality Assurance program within 4-6 weeks.