Patient Initiated Telephone Complaint/Assessment Form

Patient Name: _____

Patient Date of Birth: _____

Person completing form: _____

Relationship to Patient: _____

Treating Physician: Boisoneau ○ Dellacono ○ Gaito ○ Mlynarski ○ (circle one)

Please briefly describe your complaint :

_____

_____

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Please list any suggestions you have for resolving this matter:

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_____

Signature

_____

Date

The mission of Ear, Nose & Throat Associates of Southeastern Connecticut is to provide high-quality medical care to our patients in a courteous, cost-effective, and efficient manner consistent with the expectations of our patients and the community we service.

Thank you for taking the time to complete this form.
Please give directly to staff, fax to 860-444-2015 or
return by mail to: ENT of SECT, 14 Mason's Island Road, Unit 2B, Mystic, CT 06355

After review of all relevant information, a Patient Advocate from our office will contact you.