**Ballinteer Health Complaint Form**

Patient Full Name:

Date of Birth:

Address:

Complaint details: (Include dates, times, and names of practice personnel, if known):

Signature:

Date of submission of complaint:

Please submit this form to Reception at Ballinteer Health surgery, or email to [ballinteerhealth@gmail.com](mailto:ballinteerhealth@gmail.com) for the attention of the Practice Manager