Initial Contact
DDS Ombudsman Program

Date: ________________________________

Consumer: ____________________________ DOB: _____________________

Address: ______________________________ Telephone: ________________

______________________________ Message#: ________________

___Child ___Adult, Own Guardian ___Guardian

Responsible Party ___self ___ Other, please identify: __________________________

Additional Contact Information if different from above:

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Reason for contact with Ombudsman: ____

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Name of person submitting concern:____

Telephone: __________________ email: ____

___prefer to remain anonymous