Patient Satisfaction Survey

It is our goal to provide you with the best possible medical care. To do that, it is important that we know your thoughts about the care you are receiving. We need to know the areas in which we are doing well and the areas we need to improve. Your comments are strictly confidential and results are used to accomplish quality improvement. Please feel free to make additional comments on the back page.

1. Is this your first visit to our Practice? Yes No
   Or is this a return visit? Yes No

2. Why did you decide to seek medical treatment at this Practice? Please check all that apply.
   Sent by the emergency room
   Referred by a friend
   Selected the physician from my insurance list
   Referred by another patient
   Referred by another provider
   Near my office or home
   Other:________________________________

3. How many days in advance did you schedule your appointment?

4. Did you want to be seen sooner? Yes No

5. Was this appointment rescheduled by this Practice? Yes No

6. When you called, was the phone answered promptly? Yes No

7. Were you put on hold temporarily? Yes No

8. Did the person who answered your call identify him/herself by name? Yes No

9. Was this person courteous or discourteous (*please circle the best number with "1" indicating discourteous and "5" indicating very courteous*): 1 2 3 4 5

10. How were you treated when you arrived for your appointment? (*Please circle the best number, with "1" indicating unpleasant to "5" indicating very pleasant.*)
1 2 3 4 5

11. After you arrived, how long did you wait to see the provider? _______Minutes

12. Were you satisfied with the time the provider spent with you? (*Please circle the best number, with "1" indicating very dissatisfied to "5" being very satisfied*.)
1 2 3 4 5

13. Regarding the reason you were seen, did the provider show indifference or interest in your problem? (*Please circle the best number, with "1" indicating indifference to "5" indicating very interested*.) 1 2 3 4 5

13. Was the provider's explanation of your condition and/or treatment inadequate or excellent? (*Please circle the best number, with "1" indicating inadequate to "5" indicating excellent*.) 1 2 3 4 5

14. Were you satisfied with the overall medical treatment you received in this Practice? (*Please circle the best number, with "1" indicating very dissatisfied to "5" indicating very satisfied*.) 1 2 3 4 5

15. What do we need to change to improve our service to patients?

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If you would like someone to personally contact you about any concerns or questions you may have, please complete the following:

Name:____
Address:____
Daytime Phone:____