Patient Satisfaction Survey

Thank you for visiting our practice. We value your feedback and strive to provide the best care possible. Please take a few moments to complete this survey. Your responses are confidential and will help us improve our services.

# General Information

Date of Visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider Seen: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Please rate the following (1 = Poor, 5 = Excellent)

Ease of scheduling your appointment: 1 2 3 4 5

Friendliness and professionalism of front desk staff: 1 2 3 4 5

Wait time before being seen: 1 2 3 4 5

Time spent with provider: 1 2 3 4 5

Explanation of treatment or services: 1 2 3 4 5

Cleanliness of the office: 1 2 3 4 5

Overall experience: 1 2 3 4 5

# Additional Feedback

What did you like most about your visit?

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What can we improve?

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Would you recommend our clinic to others? Yes / No