

PATIENT SURVEY

	POOR	FAIR	GOOD	VERY GOOD	EXCELLENT
How courteous & prompt were we in scheduling your appointment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How was the care & attention you received upon arrival?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How attentive was the doctor to your problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How well did you understand the doctor's explanation of your medical condition?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How well did the doctor answer your questions?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How was the service you received from our scheduling/billing secretary?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Did you have to wait to see the doctor?
If so, how long? Yes No

DATE: _____ NAME (optional): _____

COMMENTS

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