

# PATIENT SERVICE EVALUATION

Dear Patient,

Your opinions and feelings are important to us. We at Dr. \_\_\_\_\_'s are dedicated to giving you the highest quality medical care and the best possible personal attention. We ask that you please complete this questionnaire to enable us to better serve you in the future. Your comments, good or bad, will remain anonymous.

Thank you,

Dr. \_\_\_\_\_

## How Well Did We Serve You?

### Who referred you to our office?

Friend    Family Member    HMO    Ins. Co.    Physician    Referral Service

### Did you find it easy to make an appointment?

Very easy    Easy    Not so easy    Difficult

### How would you rate our switchboard and telephone service?

Very good    Good    Average    Poor    Very poor

### Were you greeted in a friendly, courteous manner?

Very Courteous    Courteous    Not so courteous    Discourteous

### Please rate your wait time.

Very good    Good    Average    Poor    Very poor

### Were you given the time you needed with the doctor?

Yes    No

### Did the doctor explain your problem and help you to clearly understand the treatment prescribed?

Very clear    Clear    Not so clear    Not clear at all

### Did you feel that the doctor was truly concerned for your treatment and well-being?

Very concerned    Concerned    Not so concerned    Not at all concerned

### Was the staff cooperative in helping you with your insurance coverage?

Yes    No

### Would you recommend us to a friend or family member?

Yes    No

### Was our staff helpful and courteous?

Yes    No

### Did our nurses make you feel at home?

Yes    No    N/A

### Were you seen at more than one of our offices?

Yes    No    N/A

### If yes, was this convenient?

Yes    No

*Thank you for taking the time to fill out our patient service evaluation.*