Patient Satisfaction Survey

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| directions |  | Use this example document to help you visualize and then create your own custom patient satisfaction survey. |

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| Patient Satisfaction Survey sAMPLE FORMAT**Please Circle Yes or No:** |  |
| 1. Is it easy to make an appointment? | Yes | No |
| 2. Do we answer the phone promptly and politely? | Yes | No |
| 3. Does the receptionist check back within an appropriate time when kept on hold? | Yes | No |
| 4. Do we return your calls promptly? | Yes | No |

## Please choose the response that best reflects your answer based on the rating scale below:

1 = Always 2 = Usually 3 = Sometimes 4 = Rarely 5 = Never N/A = Not applicable

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **1** | **2** | **3** | **4** | **5** | **N/A** |
| Are you greeted pleasantly upon arrival? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Is our reception area clean and comfortable? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Do we see you on time? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Does our staff seem genuinely interested in you? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Are our exam rooms clean and comfortable? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Are you treated with compassion and respect? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Does the doctor and staff spend sufficient time with you? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Are the doctor and staff attentive to your needs and concerns? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Are all of your questions answered satisfactorily? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Do you receive satisfactory instructions to your | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| questions regarding prescribed treatment and medication, |  |  |  |  |  |  |
| if applicable? |  |  |  |  |  |  |
| Do we give you complete information regarding | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| insurance coverage, copayments, and fees? |  |  |  |  |  |  |

|  |  |  |
| --- | --- | --- |
| 1. In an emergency, is it easy for you to get in touch with our office?
 | Yes | No |
| 1. Are there any areas in communication or treatment you feel we could improve upon?
	* If Yes, what?
 | Yes | No |
| 1. Do you feel confident referring your friends, family, or colleagues to our practice?
 | Yes | No |
| 1. Are our office hours convenient for your schedule?
	* If No, what hours would be more convenient?
 | Yes | No |
| 1. Is our office easy to find?
 | Yes | No |
| 1. If there were one thing we could do to improve our quality of care or service, what would it be?
 | Yes | No |
|  |  |  |

If there are any other comments or concerns you would like to share with us, please use the space below.

May we use any of your comments in print and/or on our website? Yes No

Thank you for taking the time to complete this survey. Your feedback is very valuable to us! If you would like to be entered into our monthly drawing to receive a $50 credit toward future dental services, please provide us with your information below. Also, if you would like us to contact you about any questions or concerns you have, please indicate next to your name.

Name:

Phone:

Email: