Patient Feedback Form

To all patients and families of our patients, we would like to extend this opportunity to you by providing feedback to us in an effort to improve on our services. Your information will be kept confidential and you will only be contacted if you desire us to do so. Thank you for taking the time to fill this questionnaire out and allowing us the opportunity to serve you better.

1) What was the purpose of your visit to our office/clinic?

2) How was your experience in making your appointment?

- Very satisfied
- Somewhat satisfied
- Undecided
- Somewhat dissatisfied
- Very dissatisfied

3) How satisfied were you with the way you were treated by your receptionists?

- Very satisfied
- Somewhat satisfied
- Undecided
- Somewhat dissatisfied
- Very dissatisfied

4) How satisfied were you with the way you were treated by your nurse?

- Very satisfied
- Somewhat satisfied
- Undecided
- Somewhat dissatisfied
- Very dissatisfied

5) Your Doctor?

- Very satisfied
- Somewhat satisfied
- Undecided
- Somewhat dissatisfied
- Very dissatisfied

6) The amount of time you had to wait before being seen by the Doctor?

- Very satisfied
- Somewhat satisfied

- Undecided
- Somewhat dissatisfied
- Very dissatisfied

7) The amount of time you had to wait before having your labs drawn?
- Very satisfied
- Somewhat satisfied
- Undecided
- Somewhat dissatisfied
- Very dissatisfied

8) How satisfied were you with your phlebotomy experience?
- Very satisfied
- Somewhat satisfied
- Undecided
- Somewhat dissatisfied
- Very dissatisfied

9) My visit to the office/clinic was a pleasant experience.
- Strongly agree
- Agree
- Undecided
- Disagree
- Strongly disagree

10) Would you mind if we contacted you regarding any of the above issues?
- Yes
- No
- Does not matter

Optional Information. (Confidentiality Assured)

Your Name____
(PLEASE PRINT)

Number where you can be contacted :(______) ____________________

Best hours to contact you: _________AM___________PM