



PATIENT SATISFACTION SURVEY

Name of the doctor this survey is about:

(Write doctor's name here.)

To Our Patients:

We are interested in receiving your feedback about the care provided at our office. Please take a few minutes to complete this survey and return it to us. Your responses are important to us.

Please circle your responses.

How satisfied are you with the following?

Extremely Dissatisfied Very Dissatisfied Satisfied Very Satisfied Extremely Satisfied

1. Ease of making appointments for checkups (physical exams, well visits, routine follow-up appointments)?	1	2	3	4	5
2. Ease of making appointments for sickness?	1	2	3	4	5
3. Ease in contacting your doctor when our office is closed (nights and weekends)?	1	2	3	4	5
4. Ease in speaking directly with your doctor by telephone when you call during office hours?	1	2	3	4	5
5. The time it takes someone from our office to respond when you call the office with an urgent problem?	1	2	3	4	5
6. Waiting time in our office?	1	2	3	4	5
7. Ease in obtaining follow-up information and care (test results, medicines, care instructions)?	1	2	3	4	5
8. Overall medical care at your doctor's office?	1	2	3	4	5
9. Our office's appearance?	1	2	3	4	5
10. Our office's convenience (location, parking, hours, office layout)?	1	2	3	4	5
11. The way we teach you about improving your health?	1	2	3	4	5
12. The way your doctor involves other doctors and caregivers in your care when needed?	1	2	3	4	5

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Please circle your responses.

Please tell us how caring your doctor and our staff are.

	Extremely Uncaring	Very Uncaring	Caring	Very Caring	Extremely Caring
13. How caring is your doctor?	1	2	3	4	5
14. How caring is our medical staff?	1	2	3	4	5
15. How caring is our office staff?	1	2	3	4	5

	Definitely Would Not	Probably Would Not	Not Sure	Probably Would	Definitely Would
16. Would you recommend your doctor to your family or friends?	1	2	3	4	5

Please tell us:

(Reminder: These questions pertain to the patient to whom this survey was addressed – with the exception of 19, 20 and 21 which are for the responsible party.)

17. Your age in years: Less than 1 10-19 40-49 66-75
 1-4 20-29 50-59 More than 75
 5-9 30-39 60-65

18. Your gender: Male Female

19. The name of your health plan: _____

20. The name of your employer: _____

21. Please check your level of education: 8th Grade or Less Some College
 Some High School College Graduate
 High School Graduate Post-Graduate Degree

22. How long have you been a patient of this doctor? Less than 1 yr 1-4 yrs 5-9 yrs 10 yrs or more

23. How many times have you visited this doctor's office in the past 12 months for medical care?
 0 1 2 3 4 5 6 or more

Comments:

Thank you for your comments and completion of this survey.