Patient Experience Survey

Today's Date ______/________/________

Please rate the following about your visit to the office today:

		Excellent	Good	Fair	Poor
1.	The amount of time you waited to get an appointment	❑	❑	❑	❑
2.	The length of time you spent waiting at the office	❑	❑	❑	❑
3.	The amount of time spent with the provider you saw	❑	❑	❑	❑
4.	The explanation of what was done for you	❑	❑	❑	❑
5.	The personal manner (courtesy, respect, sensitivity, friendliness) of the provider you saw	❑	❑	❑	❑
6.	Staffing was sufficient to handle all of the elements of your visit	❑	❑	❑	❑
7.	The provider's sensitivity to your special needs or concerns	❑	❑	❑	❑
8.	Your satisfaction with getting the help that you needed	❑	❑	❑	❑
9.	Your satisfaction with how well this office communicates with the other providers involved in your care	❑	❑	❑	❑
10.	Your feeling about the overall quality of this visit	❑	❑	❑	❑

11. If you could go anywhere to get healthcare, would you choose this practice, or would you prefer to go somewhere else?

❑ Choose this practice ❑ Might prefer to go somewhere else ❑ Not sure

About You

12. What is your age?

❑ under 25 years ❑ 25-44 years ❑ 45-64 years ❑ 65 years+

13. Are you male or female?

❑ Male ❑ Female

Your Provider's Name: ______________________________

Your Name (Optional): ______________________________