Customer Satisfaction Survey

PATIENT INFORMATION

Name: _____ Date of Visit: _____ dd / mm / yyyy

Service or Treatment Received: _____

SURVEY QUESTIONS

How satisfied were you with your overall experience at our healthcare practice?

- ◯ Very Satisfied
- ◯ Satisfied
- ◯ Neutral
- ◯ Dissatisfied
- ◯ Very Dissatisfied

How would you rate the quality of care you received?

- ◯ Very Satisfied
- ◯ Satisfied
- ◯ Neutral
- ◯ Dissatisfied
- ◯ Very Dissatisfied

How satisfied were you with the interactions you had with our staff (including doctors, nurses, and administrative staff)?

- ◯ Very Satisfied
- ◯ Satisfied
- ◯ Neutral
- ◯ Dissatisfied
- ◯ Very Dissatisfied

How do you feel about the wait time for your appointment?

- ◯ Very Satisfied
- ◯ Satisfied
- ◯ Neutral
- ◯ Dissatisfied
- ◯ Very Dissatisfied

How well did our staff explain your treatment and answer your questions?

- ◯ Very Satisfied
- ◯ Satisfied
- ◯ Neutral
- ◯ Dissatisfied
- ◯ Very Dissatisfied

How would you rate the cleanliness and comfort of our facility?

- ◯ Very Satisfied
- ◯ Satisfied
- ◯ Neutral
- ◯ Dissatisfied
- ◯ Very Dissatisfied

How likely are you to recommend our practice to family and friends?

- ◯ Very Satisfied
- ◯ Satisfied
- ◯ Neutral
- ◯ Dissatisfied
- ◯ Very Dissatisfied

Do you have any other comments, questions, or concerns?

SPECIFIC STAFF FEEDBACK

Are there staff members you would like to mention for their exceptional or poor service?

Staff Name: _____

Comments

Staff Name: _____

Comments

Staff Name: _____

Comments

ADDITIONAL SERVICES OR IMPROVEMENTS

Are there any services or improvements you would like to see in our practice?

Thank you for taking the time to complete our survey! Your feedback is invaluable in helping us improve our services and patient care.