Patient Satisfaction Survey

Patient information: _____ Healthcare provider: _____

Date of visit: _____ dd / mm / yyyy

QUALITY OF CARE

How would you rate the quality of care you received during your visit?

◯ ◯ ◯ ◯ ◯
1 2 3 4 5

How satisfied were you with the explanation of your diagnosis and treatment plan?

◯ ◯ ◯ ◯ ◯
1 2 3 4 5

How would you rate the friendliness and compassion of your healthcare provider?

◯ ◯ ◯ ◯ ◯
1 2 3 4 5

How confident do you feel about following your treatment plan?

◯ ◯ ◯ ◯ ◯
1 2 3 4 5

FACILITY

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

◯ ◯ ◯ ◯ ◯
1 2 3 4 5

How would you rate the availability and convenience of appointment scheduling?

◯ ◯ ◯ ◯ ◯
1 2 3 4 5

Was the wait time for your appointment reasonable?

◯ Yes ◯ No ◯ Not sure

COMMUNICATION

How would you rate the communication and professionalism of your healthcare provider?

◯ ◯ ◯ ◯ ◯
1 2 3 4 5

Were your questions and concerns addressed during your visit?

◯ Yes ◯ No ◯ Not sure

Were you satisfied with the amount of time you spent with your healthcare provider during your visit?

◯ Yes ◯ No ◯ Not sure

COST

Was the overall cost of your visit reasonable?

◯ Yes ◯ No ◯ Not sure

Were you satisfied with the payment options available?

◯ Yes ◯ No ◯ Not sure

OVERALL

How likely are you to recommend this healthcare provider to others?

1 2 3 4 5

ADDITIONAL COMMENTS

Specify below: