

Patient Satisfaction Survey

In an effort to help ensure the highest quality of patient care at our practice, please complete the following questionnaire and return it to us as soon as possible after your appointment.

Date of your visit? _____ Provider? Dr. Brad Abrams Sheryl Wilson, ARNP-C Catherine Deans, LE

| | | | | |
|------|------------------|---------|-----------|-----------|
| 1 | 2 | 3 | 4 | 5 |
| Poor | Need Improvement | Average | Very Good | Excellent |

1. How professional and courteous was our staff on the phone? Please select

2. During your office visit, how well did we listen to your specific needs? Please select

3. How would you rate the value of the services and products you received? Please select

4. How courteous and professional was our staff during every aspect of your visit? Please select

5. Would you recommend our practice to your family and friends? Please select

6. What did you like best about your experience in our office?

7. Do you have any recommendations that could improve the performance of our office?

8. Did your appointment begin within 15 minutes of the scheduled time? Yes No

9. Did the staff explain your wound care instructions & provide you with a handout? yes No

10. Overall, do you believe the time you spent in our office was (check one)?

Comprehensive, just what I thought.

Too long, could have taken less time.

Too short, not enough time taken on my specific needs.

11. How did you first hear about this dermatology practice?

Website/Internet Newspaper Yellow Pages Mailer Referral Friend/Family Doctor

Window sign Insurance Plan Other _____

12. Were all of your questions or concerns answered? yes No

Would you like to be contacted regarding your comments on this survey? Yes No

If Yes, please include your information below.

Name: _____ Phone: _____

Thank you for your time and continued patronage