PATIENT SATISFACTORY SURVEY

Thank you for choosing our office for your allergy care. In an effort to improve our services to you, we are asking you to take a few minutes to complete this survey. We value your opinion. Your frank feedback (positive or negative) would be very valuable to us. Sign your name only if you want to.

Your Name:_____ Is this your first visit? _____
Time/Day of week:_____

1. What is the name of the doctor / nurse who you saw today? _____
2. What service did you receive today? Consult / Shot / Testing (circle one).
3. What was your total length of visit? _____
4. Before you came to this office, did you receive information on:

Directions to the office:	_____Yes	No_____	NA_____
Was it helpful?	_____Yes	No_____	NA_____
Fees and billing:	_____Yes	No_____	NA_____
If yes, was it helpful	_____Yes	No_____	NA_____

Circle the level of satisfaction that best reflects your experience with the following aspects of our office:

1 = Very Dissatisfied 2 = Dissatisfied 3 = Neutral
4 = Satisfied 5 = Very Satisfied

1. Calling our office to make an appointment	1	2	3	4	5
2. Time between making an appt. and being seen	1	2	3	4	5
3. Time spent waiting in reception area	1	2	3	4	5
4. Time spent waiting in exam room	1	2	3	4	5
5. Was waiting room comfortable	1	2	3	4	5
6. Receptionist was friendly and courteous	1	2	3	4	5
7. Procedure performed was explained by Nurse	1	2	3	4	5
8. Sensitivity of Doctor to your illness	1	2	3	4	5
9. Questions were answered adequately by staff	1	2	3	4	5
10.How satisfied are you with the overall care	1	2	3	4	5
11.Would you recommend this office to a friend	1	2	3	4	5

PLEASE ADD YOUR COMMENTS: _____

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Could we post your comments on our website _____Yes _____No