

## Your Opinion: Patient Satisfaction Evaluation

Thank you for taking the time to complete this survey. We value your opinion, observations, and suggestions. We hope to continually improve our practice from the information that our patients give to us.

**How did you become a patient at our practice? (Please check one)**

- Referred by a physician
- Referred by a family member or friend
- Advertisement in the NewsPress
- TV Spot
- Internet search
- Telephone book
- Other

**How long have you been a patient/parent at this practice? (Please check one)**

- First visit
- Less than one year
- One to six years
- Returning patient

**Which office were you seen at most recently?**

- Cape Coral Offices
- Main office (6120 J)
- 6120H for Follow up or new patient exam

**Please check the block that you think describes each topic.**

Appearance	Exceptional	Good	Average	Unsatisfactory
Waiting Room	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Front Office	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exam Room	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Procedure Room	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recovery Room	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Staff Service	Exceptional	Good	Average	Unsatisfactory
Appointment Person	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Check-In	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Front Office	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clinical Staff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nurse Practitioner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physician	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Procedure Room	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insurance Department	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recovery Room	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

