

PARENT/PATIENT SURVEY

In an ongoing effort to improve our service to you, please answer this survey and return it to us at your convenience in the enclosed self-addressed, stamped envelope.

1. Overall, did we meet your expectations for treatment? *yes*

In what ways? *100%*

2. What would have increased your satisfaction?

3. Did our office hours meet your needs? *yes*

Were we on time or did you have to wait to be seen? *on time*

4. Are you satisfied with the explanations given to you by Dr. Alford concerning treatment? *yes*

Are you satisfied with the explanations of treatment given to you by our office staff? *yes*

5. How would you rate us in the following areas?

1 = needs improvement    2 = good    3 = excellent

	<u>Dr. Alford</u>			
Friendliness:		1	2	<u>3</u>
Caring/Concern:		1	2	<u>3</u>
	<u>Staff</u>			
Friendliness:		1	2	<u>3</u>
Caring/Concern:		1	2	<u>3</u>
	<u>Office</u>			
Cleanliness:		1	2	<u>3</u>
Equipment:		1	2	<u>3</u>
Present location:		1	2	<u>3</u>

6. Please add any additional comments concerning any situation, staff member, or Dr. Alford.

Signature (optional): *Dina H. Alford*

May we share this information with others (and for our website)? *yes*