

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?

2. What would have increased your satisfaction?

Nothing! Very happy!

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

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

Signature (optional): *[Handwritten Signature]*

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