Date: _____
Doctor: _____
Surgical Assistant: _____

We would appreciate your help in improving our standard of care and quality of service to our patients. Please take the time to fill out the following survey and return to us in the self addressed envelope provided.

1. What are we doing that you like?

2. Are there any areas that need improvement?

3. Could we have made your visit more pleasant?

4. How would you rate your treatment in our office?

   □ Excellent
   □ Very Good
   □ Fair
   □ Needs Improvement
   □ Poor

   Comments: _____
   _____

5. How would you rate our administration care (billing, scheduling, etc.)?

   □ Excellent
   □ Very Good
   □ Fair
   □ Needs Improvement
   □ Poor

   Comments: _____
   _____

Thank you for taking the time to provide us with this important feedback. We feel the quality of patient care is the best indicator of a good practice.

Sincerely, _____
(Signature Optional)