

# How Did We Do?

Date \_\_\_\_\_ Time \_\_\_\_\_

1. What was the purpose of your visit today?

- Primary Care/Physical
- Urgent Care
- Radiology
  - CT,
  - Ultrasound,
  - Echo,
  - XRay,
  - Mammography

2. Have you been a patient here before?

- Yes
- No

3. Were you treated in a friendly and courteous manner?  Yes  No

a prompt manner?  Yes  No

4. What one thing could our team have done to improve your visit today?

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5. Did any of our staff provide exceptional service on your visit today? If so please let us know, we like to acknowledge our staff.

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6. Would you recommend this practice to a friend?  Yes  No

\* If not, would you mind telling us why?

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7. Rate your overall satisfaction with your visit today. 1 being the least satisfied 5 being most satisfied

- 1
- 2
- 3
- 4
- 5

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