ADVANCED EYE INSTITUTE

Patient Satisfaction Survey

Patient Name (optional): _____

Date of Service: _____ Appointment Time: _____

At Advanced Eye Institute, we are always striving to better ourselves and your overall experience. Please take a moment to let us know how we are doing!!
Please circle a number, 5 being an excellent experience and 1 being the worst.

1. Ease of booking an appointment	1	2	3	4	5
2. Friendliness of check-in staff	1	2	3	4	5
3. Rate your wait time	1	2	3	4	5
4. Technician friendliness & knowledge	1	2	3	4	5
5. Overall physician interaction & knowledge	1	2	3	4	5
6. Friendliness of optical staff (if N/A please leave blank)	1	2	3	4	5
7. Friendliness of check-out staff	1	2	3	4	5

8. What was the total time spent in the office today?

_____

9. Did anyone go out of their way to make your experience wonderful?

_____

10. Please rate your overall experience.	1	2	3	4	5

COMMENTS:

_____
_____
_____
_____
_____
_____

Please place in patient mailbox, outside of checkout window! Thank you for your help!