



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!