

## PATIENT SATISFACTION SURVEY



We are interested in receiving your feedback about the care provided at our office. Please take a few minutes to complete this survey and return it to us. Your responses are important to us.

Please circle your responses.

How satisfied are you with the following?	Extremely Dissatisfied	Very Dissatisfied	Satisfied	Very Satisfied	Extremely Satisfied
1. Ease of making appointment for checkups (physical exams, well visits, routine follow-up appointments)?	1	2	3	4	5
2. Ease of making appointments for sickness?	1	2	3	4	5
3. Ease in contacting your our office is closed (nights and weekends)?	1	2	3	4	5
4. Ease in speaking directly with your provider by telephone when you call during office hours?	1	2	3	4	5
5. The time it takes someone from our office to respond when you call the office with an urgent problem?	1	2	3	4	5
6. Waiting time in our office?	1	2	3	4	5
7. Ease in obtaining follow-up information and care (test results, medicines, care instructions)?	1	2	3	4	5
8. Overall medical care at your our office?	1	2	3	4	5
9. Our office's appearance?	1	2	3	4	5
10. Our office's convenience (location, parking, hours, office layout)?	1	2	3	4	5
11. The way we teach you about improving your health?	1	2	3	4	5
12. The way your provider involves other providers and caregivers in your care when needed?	1	2	3	4	5

How caring would you say the following individuals are?	Extremely Uncaring	Very Uncaring	Caring	Very Caring	Extremely Caring
13. Your provider?	1	2	3	4	5
14. Our medical staff?	1	2	3	4	5
15. Our office staff?	1	2	3	4	5
	Definitely Not	Probably Not	Not Sure	Probably	Definitely
16. Would you recommend your provider to your family or friends?	1	2	3	4	5

Continued ►

These questions pertain to the patient to whom this survey was addressed:

17. Age in years:      ☐ 20-29              ☐ 40-49              ☐ 66-75  
                                 ☐ 30-39              ☐ 50-59              ☐ 75+  
                                 ☐ 60-65

18. How many times have you visited this provider's office in the past 12 months for medical care?

- ☐ 0              ☐ 1              ☐ 2              ☐ 3              ☐ 4              ☐ 5              ☐ 6 or more

These questions pertain to the responsible party:

19. The name of your health plan: \_\_\_\_\_

20. The name of your employer: \_\_\_\_\_

21. Your level of education:

- |   |   |
|---|---|
| <input type="checkbox"/> 8th grade or less    | <input type="checkbox"/> Some college         |
| <input type="checkbox"/> Some high school     | <input type="checkbox"/> College graduate     |
| <input type="checkbox"/> High school graduate | <input type="checkbox"/> Post-graduate degree |

Comments:



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