

DENTAL SERVICES SURVEY

We thank you in advance for completing this questionnaire. When you have finished, please mail it in the enclosed envelope.

THE SERVICE YOU RECEIVED (SELECT ONE RESPONSE ONLY)

Please select the last *service* you received. Rate only that service and visit.

- | | | |
|--|---|--|
| <input type="radio"/> Cleaning | <input type="radio"/> Cosmetic (bleaching, bonding) | <input type="radio"/> Orthodontic (braces) |
| <input type="radio"/> Regular/Routine Exam | <input type="radio"/> Emergency Care | <input type="radio"/> Dentures |
| <input type="radio"/> Restoration (filling, crown, bridge) | <input type="radio"/> Periodontic (gum disease) | <input type="radio"/> Implants |
| <input type="radio"/> Extraction (tooth pulled) | <input type="radio"/> Endodontic (root canal) | <input type="radio"/> Oral Surgery |

BACKGROUND INFORMATION

1. Was this the first time you have used our practice?..... Yes No

INSTRUCTIONS: Please rate the services you received from our facility. Select the response that best describes your experience. If a question does not apply to you, please skip to the next question. Space is provided for you to comment on good or bad things that may have happened to you.

Please use black or blue ink to fill in the circle completely.
Example: ●

ACCESS	very poor 1	poor 2	fair 3	good 4	very good 5
1. Availability of appointments at day/time that met your needs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Ease of scheduling your appointment.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Ease of contacting (e.g., email, phone, internet) the dental office.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Comments (describe good or bad experience): _____

MOVING THROUGH YOUR VISIT	very poor 1	poor 2	fair 3	good 4	very good 5
1. Ease of the check-in process.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. How well you were kept informed about any delays	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Wait time at the dental office (from arriving to leaving)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Comments (describe good or bad experience): _____

DENTAL TEAM	very poor 1	poor 2	fair 3	good 4	very good 5
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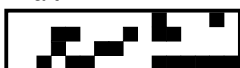
The Dental Assistant was the person who took your medical information and assisted the dentist when they treated you. Please answer the following questions with that person in mind. If you did not see a Dental Assistant during your visit, please skip these questions.

- | | | | | | |
|--|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| 1. How well the dental assistant listened to you..... | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 2. Dental assistant's explanation of the things they did with you during your visit..... | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

The Dental Hygienist was the person who cleaned your teeth. Please answer the following questions with that person in mind. If you did not see a Dental Hygienist during your visit, please skip these questions.

- | | | | | | |
|--|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| 1. How well the dental hygienist listened to you..... | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 2. Information the dental hygienist gave you about oral hygiene (brushing, flossing, etc.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 3. Dental hygienist's discussion of the outcome of your cleaning/oral exam | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Comments (describe good or bad experience): _____



DENTIST	very				very
	poor	poor	fair	good	good
	1	2	3	4	5

- | | | | | | |
|--|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| 1. How well the dentist listened to you | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 2. Explanations the dentist gave you about your problem or condition..... | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 3. Dentist's efforts to include you in decisions about your care | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 4. Dentist's discussion of any proposed treatment (options, risks, benefits, etc.) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 5. Likelihood of your recommending this dentist to others | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Comments (describe good or bad experience): _____

OVERALL ASSESSMENT	very				very
	poor	poor	fair	good	good
	1	2	3	4	5

- | | | | | | |
|---|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| 1. If you felt nervous or afraid while at the dental office, support the staff
(including the dentist) gave you..... | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 2. How well the staff (including the dentist) worked together to care for you | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 3. Likelihood of your recommending this dental office to others | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Comments (describe good or bad experience): _____

Patient's Name: (optional) _____

Telephone Number: (optional) _____

