

Specialists in Dermatology, PLLC Patient Questionnaire

In an effort to better serve our patients, we are conducting a patient survey to get your opinions on the services that we provide. Please take a few moments to complete this questionnaire by checking off the response which is most accurate.

How did you first hear about our office? *(please select one)* Today's Date: _____

Near home or business Referral by another patient Telephone Listing You Participate in My Health Plan Other – please explain: _____.

Physician Referral Referring Physician's Name: _____

How long have you been a patient at our office: First Visit 1-5 Years Over 5 Years

Your Appointment	Excellent	Very Good	Good	Fair	Poor	N/A
1. Ease of scheduling your appointment by phone:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Appointment available within a reasonable amount of time:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. The promptness and efficiency of the check-in process:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Waiting time in the reception area:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Did not wait <input type="checkbox"/> 1-10 minutes <input type="checkbox"/> 11-20 minutes <input type="checkbox"/> 21-30 minutes <input type="checkbox"/> More than 30 minutes <input type="checkbox"/> +45 minutes						
5. Were you informed that your provider was running late?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A			

Our Staff

1. The courtesy of the scheduling staff was:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. The friendliness and courtesy of the receptionist:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. The care that you received from our medical assistant was:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. The helpfulness of the people in our business office:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Our Communication With You

1. Your phone call was answered promptly:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Did we return your calls in a timely manner?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Your test results reported in a reasonable amount of time:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Your ability to contact us after hours in an emergency:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Your ability to obtain prescription refills by phone:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Specialists in Dermatology Physician/Physician Assistant that saw you: _____

1. Waiting time spent in the exam room before seeing the doctor/physician assistant (P.A.):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Did not wait <input type="checkbox"/> 1-10 minutes <input type="checkbox"/> 11-20 minutes <input type="checkbox"/> 21-30 minutes <input type="checkbox"/> More than 30 minutes <input type="checkbox"/> +45 minutes						
2. Did you find the doctor/P.A. friendly and courteous?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Amount of time the doctor/P.A. spent with you:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. The doctor/P.A. took time to answer your questions:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. The thoroughness of the examination:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. The doctor/P.A. adequately explained treatment options:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please Turn Over To Complete the Survey ↓

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Our Facility

Excellent Very Good Good Fair Poor N/A

- | | | | | | | |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. Availability of parking: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Hours of operation: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Overall comfort of office surroundings: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Signage and directions easy to follow: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Your Overall Satisfaction With

- | | | | | | | |
|--------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. Our practice: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. The quality of your medical care: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Would you recommend a friend or family to our facility?

YES NO

If no, please explain why:

On A Scale of 1 (Poor) to 10 (Excellent) How Would You Rate Your Visit?

1 2 3 4 5 6 7 8 9 10

What Would It Take To Make It A 10?

Additional comments:

May we use your comments on our website? Yes No

Your Name (optional):_____

Your Telephone Number (optional):_____

We truly appreciate your feedback. Any additional comments or suggestions you make will help us to serve you better.