

WESTERN WAYNE FAMILY PHYSICIANS

PATIENT SATISFACTION SURVEY

In an attempt to improve the quality of care we provide, we would like to know how you feel about the service we provide to you. All responses will be kept confidential.

Thank you for your time.

Age: _____ Physician: _____ Gender: _____

Great Good OK Fair Poor

Ease of getting care:

Ability to get an Appointment	5	4	3	2	1
Hours our office is open	5	4	3	2	1
Convenience of our location	5	4	3	2	1
Prompt return of calls	5	4	3	2	1
Getting care before or after office hours	5	4	3	2	1
Getting referrals to specialists	5	4	3	2	1

Waiting:

Time in waiting room	5	4	3	2	1
Time in exam room	5	4	3	2	1
Waiting for tests to be performed	5	4	3	2	1
Waiting for test results	5	4	3	2	1

Staff:

Physician:

Listens to you	5	4	3	2	1
Takes enough time with you	5	4	3	2	1
Explains what you want to know	5	4	3	2	1
Gives you good advice and treatment	5	4	3	2	1

Nurse and Medical Assistant:

Friendly and helpful to you	5	4	3	2	1
Answers your questions	5	4	3	2	1

Receptionist:

Friendly and helpful to you	5	4	3	2	1
Answers your questions	5	4	3	2	1

Great Good OK Fair Poor

Facility:

Neat and clean building	5	4	3	2	1
Ease of finding where to go	5	4	3	2	1
Comfort and safety while waiting	5	4	3	2	1
Privacy	5	4	3	2	1

Likelihood of referring people to us 5 4 3 2 1

Do we provide your main source of care? **YES** **NO**

Do you have a chronic health condition? **YES** **NO**

If you answered yes, what is that condition(s): _____

Do we manage the care for this condition? **YES** **NO**

If yes, how well do you feel that care is 5 4 3 2 1

What do you like best about our office? _____

What do you like least about our office? _____

Any suggestions for improvement? _____

THANK YOU FOR YOUR PARTICIPATION