



# Patient Experience Survey

Date: \_\_\_\_\_

We would like to know how you feel about the services we provide so we can make sure we are meeting your needs. Your responses are directly responsible for improving these services. All responses will be kept confidential and anonymous. Thank you for your time.

Patient Age: \_\_\_\_\_ Patient Race/Ethnicity\_\_\_ Black/African American  
 \_\_\_ White (Not Hispanic or Latino)  
 Patient Sex: \_\_\_ Female \_\_\_ Asian  
 \_\_\_ Male \_\_\_ Hispanic or Latino (All Races)  
 \_\_\_ Other \_\_\_ Other  
 \_\_\_ Unknown

Are you: \_\_\_ The Patient Patient Insurance: \_\_\_ Private/Commercial  
 \_\_\_ Primary Care Giver \_\_\_ Medicaid/SCHIP  
 \_\_\_ Secondary Care Giver \_\_\_ Medicare  
 \_\_\_ Parent/Legal Guardian \_\_\_ Medicare and Medicaid  
 \_\_\_ Spouse \_\_\_ Uninsured/Self Pay  
 \_\_\_ Sibling \_\_\_ Other  
 \_\_\_ Child  
 \_\_\_ Extended Family Member Residence: \_\_\_ Family/Permanent Residence  
 \_\_\_ Long Term Care  
 \_\_\_ Foster Care  
 \_\_\_ No Permanent Residence  
 \_\_\_ Other

Primary Care Provider Name: \_\_\_\_\_

Please circle how well you think we are doing in the following areas:	GREAT	GOOD	OK	FAIR	POOR
	5	4	3	2	1
<b>Ease of getting care:</b>					
Ability to get in to be seen	5	4	3	2	1
Hours clinic open	5	4	3	2	1
Convenience of clinic's location	5	4	3	2	1
Prompt return on calls	5	4	3	2	1
<b>Waiting:</b>					
Time in waiting/exam room	5	4	3	2	1
Waiting for referrals to specialist appointments	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
<b>Staff:</b>					
<i>Provider:</i> (Physician, Dentist, Physician Assistant, Nurse Practitioner)					
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
Please circle how well you think we are doing in the following areas:	GREAT 5	GOOD 4	OK 3	FAIR 2	POOR 1
<i>Nurses and Medical Assistants:</i>					
Friendly and helpful to you	5	4	3	2	1
Answers your questions	5	4	3	2	1
<i>All Other Staff:</i>					
Friendly and helpful to you	5	4	3	2	1
Answers your questions	5	4	3	2	1
Payment:					
What you pay	5	4	3	2	1
Explanation of charges	5	4	3	2	1
Collection of payment/money	5	4	3	2	1
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
Confidentiality:					
Keeping my personal information private	5	4	3	2	1
The likelihood of referring your friends and relatives to us:	5	4	3	2	1
<b>Do you consider this clinic your regular source of care?                      Yes _____ No _____</b>					

What do you like best about our clinic? \_\_\_\_\_

\_\_\_\_\_

What do you like least about our clinic? \_\_\_\_\_

\_\_\_\_\_

Suggestions for improvement \_\_\_\_\_

\_\_\_\_\_

Thank you for completing our survey!