How Did We Do?

Please mail this questionnaire to our office or leave it with a member of our staff... your opinion is important!

1. Do you feel that you and/or your child received adequate personal attention from us? Yes _____ No _____ Comments _____

2. Did the office environment meet your expectations? Yes _____ No _____

Suggestions _____

3. Was the staff caring and supportive? Yes _____ No _____

4. Were the details of your condition and recommended treatment explained to your satisfaction? Yes _____ No _____

5. Are you happy with you/your child's treatment results? Yes _____ No _____ Comments _____

6. Were the cost of treatment, insurance issues, and payment options clearly explained? Yes _____ No _____ Suggestions _____

7. We try to treat our patients so well that they will want to recommend us to their friends and family. Did we achieve this with you? Yes _____ No _____

8. Please use this space for any additional comments that may help us serve others better. _____

_____

_____

_____

Name _____ Date _____
(OPTIONAL)

Thank you for taking the time to complete this assessment. Your input is greatly appreciated.

Fairfield Oral and Maxillofacial Surgery
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