

Client Feedback Form

Name	
Date of Scan	
Type of Scan	
I agree to receive additional Information	
How did you hear about us?	
Would you recommend our clinic to friends or family?	
Would you be interested in any of our other services or products?	
Did your appointment start early, late or on time?	<input type="checkbox"/> 10 or more minutes early <input type="checkbox"/> On time <input type="checkbox"/> 10 or more minutes late
What was good about your visit?	
What would have made your visit better?	
Please tell us why you gave your response?	
Please rate your experience 10 being 'Excellent' 1 being 'I found an issue & I'd like to speak to a manager'	Great ----- Poor 10 9 8 7 6 5 4 3 2 1