Patient Feedback Form

Patient Name: _____ Date & Time: _____

Doctor Name: _____ Clinic: _____

Reason for Visit: _____

_____

1. **How was your experience making an appointment?**
   - ❑ Exceptional
   - ❑ Satisfactory
   - ❑ Adequate
   - ❑ Unsatisfactory

   Comments: _____

2. **How was your experience checking in with reception?**
   - ❑ Exceptional
   - ❑ Satisfactory
   - ❑ Adequate
   - ❑ Unsatisfactory

   Comments: _____

3. **How was your experience with wait time?**
   - ❑ Exceptional
   - ❑ Satisfactory
   - ❑ Adequate
   - ❑ Unsatisfactory

   Comments: _____

4. **How was your experience with the nurse?**
   - ❑ Exceptional
   - ❑ Satisfactory
   - ❑ Adequate
   - ❑ Unsatisfactory

   Comments: _____

5. **How was your experience with the doctor?**
   - ❑ Exceptional
   - ❑ Satisfactory
   - ❑ Adequate
   - ❑ Unsatisfactory

   Comments: _____

All information provided in this feedback form will be kept confidential and used only to help us provide a better experience for our patients. Thank you!