

## Seaview Orthopaedic & Medical Associates Patient Survey

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

Doctor Seen: \_\_\_\_\_

Name (Optional): \_\_\_\_\_

Office Seen In: \_\_\_\_\_

Please answer the survey questions for your physician. Additional comments may be written at the end. Consider “what was good” about your consultation and “what could be better.”

### *How satisfied were you with:*

	Highly Satisfied	Neutral	Dissatisfied	Highly Dissatisfied
The registration process				
The timeliness of your appointment				
The way information was shared with you				
The overall care given by the staff				
The overall care given by the doctor				

### *How much do you agree with the following?*

	Highly Agree	Agree	Disagree	Highly Disagree
The doctor treated me with respect				
The doctor listened to me				
The doctor seemed to care about my feelings				
The doctor and staff worked well as a team				
The doctor told me all I needed to know				
The staff helped me when I needed help				
I felt comfortable asking questions				
I was comfortable during the exam				
I understand the proposed treatment plan				
I know who to call if I have questions				

**Yes or No**

I would recommend Dr. \_\_\_\_\_ to my family and friends.  Yes  No

I would return to Seaview Orthopaedics for other treatments.  Yes  No

My consultation was for \_\_\_\_\_

**Optional (Circle and Complete)**

Gender:      Male                  Female

Ethnicity:    African-American      Caucasian                  Asian                  HispanicOther

Age:                  \_\_\_\_\_ years

To expand upon any answers, please complete: \_\_\_\_\_

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