

Patient Satisfaction Survey

1. Which provider did you see today:
 - a. Sherry Kent, FNP
 - b. Carolina Griffin, FNP
2. Today's Date: _____
3. Day of Service:
 - a. Monday
 - b. Tuesday
 - c. Wednesday
 - d. Thursday
 - e. Friday
4. Are you a New Patient or Established Patient:
 - a. New Patient
 - b. Established
5. What is your Age: _____
6. What is your Gender:
 - a. Male
 - b. Female
7. What is your Race/Ethnicity:
 - a. White/Caucasian
 - b. Black/African American
 - c. Asian
 - d. American Indian
 - e. Other _____
8. Are you Hispanic/Latino:
 - a. Yes – I am Hispanic or Latino
 - b. No – I am NOT Hispanic or Latino
9. Do you consider this your regular primary source of care?
 - a. Yes
 - b. No
10. What is the highest grade level of school that you have completed?
 - a. 8th grade or less
 - b. Some high school but did not graduate
 - c. High school graduate or GED
 - d. Some college or 2 year degree
 - e. 4 year college graduate
 - f. Advanced graduate degree or more than 4 years of college
11. Did someone help you complete this survey?
 - a. Yes
 - b. No
12. How did someone help you with completing this survey (circle all that apply)?
 - a. Read the questions to me
 - b. Selected the responses that I gave
 - c. Answered the questions for me
 - d. Translated the questions into my language
 - e. Other

How would you rate the following:

Ease of Getting Care

	Great	Good	OK	Fair	Poor
Ability to be Seen					
Office Hours					
Prompt Return Calls					

Wait Times

	Great	Good	OK	Fair	Poor
Appointment Wait Time					
Lab Draw Wait Time					
Test Result Wait Time					
Referral Wait Time					

Your Provider/Clinician

	Great	Good	OK	Fair	Poor
Listens to you					
Takes enough time with you					
Explains what you want to know					
Gives you good advice and treatment					

Staff (Nurses, Medical Assistants, Office Staff, etc)

	Great	Good	Ok	Fair	Poor
Friendly and Helpful					
Answers your Questions					

Confidentiality

	Great	Good	OK	Fair	Poor
Keeping my personal information private					

If not great, please explain: _____

About You

In General:	Great	Good	OK	Fair	Poor
How would you rate your overall health					
How would you rate your overall MENTAL or EMOTIONAL health					

If not great, what can we do to help? _____

Additional Comments: _____

If you would like someone to follow-up on your comments please provide additional information:

Full Name: _____

Telephone Number: _____