I Dear Patient*

We want to give you the best possible eye care! To assure that, we need your feedback because your comments and opinions are important to us. Please take a few moments to fill out this brief survey.

1. How many miles did you travel to get to our offi
   - ☐ Under 1 mile
   - ☐ 1-3 miles
   - ☐ 3-5 miles
   - ☐ Over 10 miles

2. Which of the following influenced your decision to come to our office? (Check all that apply)
   - ☐ Referred by another patient name: _____
   - ☐ Referred by another doctor name: _____
   - ☐ Referred by a friend or family member name: _____
   - ☐ Newspaper ad which newspaper:_____
   - ☐ Magazine ad or article which magazine: _____
   - ☐ Radio ad which station: _____
   - ☐ Close to home or office
   - ☐ Other Please specify _____

3. How long did you wait to be seen beyond your scheduled appointment time?
   ------ minutes

4. Please rate us P = Poor F = Fair G = Good E = Excellent

   _____ Courtesy and helpfulness of our reception staff when you called for an appointment
   _____ Ability to get a timely appointment
   ___ Reception area
   _____ Appearance and neatness of our staff
   —:— Waiting time past appointment time
   _____ Exam Room
   _____ Courtesy of doctor
   _____ Doctor's patience and interest in your problem
   _____ Time doctor spent with you
   _____ Doctor's explanation and treatment
   ___ General quality of medical care you received
   _____ Explanation of billing
   _____ Other _____ . _____

Thank you for helping us. Please mail this survey to our office, or
E-mail to passaicvision@aol.com

PatientRelations
Director

Isabel Mejia

CLIFTON&PASSAIC EYE SPECIALISTS 1
Ilustración 1