

# How Did We Do?

*Please mail this questionnaire to our office or leave it with a member of our staff... your opinion is important!*

1. Do you feel that you and/or your child received adequate personal attention from us?  
Yes \_\_\_\_\_ No \_\_\_\_\_ Comments \_\_\_\_\_

2. Did the office environment meet your expectations? Yes \_\_\_\_\_ No \_\_\_\_\_

Suggestions \_\_\_\_\_

3. Was the staff caring and supportive? Yes \_\_\_\_\_ No \_\_\_\_\_

4. Were the details of your condition and recommended treatment explained to your satisfaction? Yes \_\_\_\_\_ No \_\_\_\_\_

5. Are you happy with you/your child's treatment results? Yes \_\_\_\_\_ No \_\_\_\_\_

Comments \_\_\_\_\_

6. Were the cost of treatment, insurance issues, and payment options clearly explained?

Yes \_\_\_\_\_ No \_\_\_\_\_ Suggestions \_\_\_\_\_

7. We try to treat our patients so well that they will want to recommend us to their friends and family. Did we achieve this with you? Yes \_\_\_\_\_ No \_\_\_\_\_

8. Please use this space for any additional comments that may help us serve others better.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name \_\_\_\_\_

(OPTIONAL)

Date \_\_\_\_\_

Thank you for taking the time to complete this assessment. Your input is greatly appreciated.

## **Fairfield Oral and Maxillofacial Surgery**

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