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Patient Satisfaction Survey

We would like to know how you feel about the services we provide so we can make sure we are meeting your needs. Your responses are directly responsible for improving our services. Your responses will be kept in confidence and only reviewed by our administrative staff.

Thank you for your time.

Your Age:

How far did you travel to get here today? _____

| Gender: | | | | | _ |
|--|---------------|--------------|------------|-----------|--------------|
| How do you rate? (Please circle the appropriate number) | Excellent | Very Good | Fair | Poor | Very Poor |
| The Dental staff is nice and polite. | 5 | 4 | 3 | 2 | 1 |
| The Dental staff verified your identity (date of birth or chart number or ID card). | 5 | 4 | 3 | 2 | 1 |
| The Dental staff's explanation of your treatment was good and understandable | 5 | 4 | 3 | 2 | 1 |
| 4. The Dental Assistant treated you well. | 5 | 4 | 3 | 2 | 1 |
| 5. The amount of time you spent with the Dentist today was adequate for your treatment. | 5 | 4 | 3 | 2 | 1 |
| 6. The Dentist listened to you. | 5 | 4 | 3 | 2 | 1 |
| 7. The Dental staff respected your privacy during your visit today. | 5 | 4 | 3 | 2 | 1 |
| 8. Overall, the care you received in the Dental Department at Tohatchi Health Center meets your needs. | 5 | 4 | 3 | 2 | 1 |
| The time spent waiting to be seen today was reasonable. | 5 | 4 | 3 | 2 | 1 |
| The staff assessed and addressed your pain level today. | 5 | 4 | 3 | 2 | 1 |
| Do you have any suggestions or co services? | omments as to | how we n | nay better | improve o | ur |

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0917-0036. The time required to complete this information collection is estimated to average five minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: U.S. Department of Health & Human Services, OS/OCIO/PRA, 200 Independence Ave., S.W., Suite 336E, Washington D.C. 20201, Attention: PRA Reports Clearance Officer.

Thank you for taking the time to complete this survey. Your opinion means a lot to