**PATIENT SATISFACTION SURVEY**

**WOODROW WILSON KEEBLE MEMORIAL HEALTH CARE CENTER**

**Dental Department**

*The Dental Department kindly asks you to complete this survey. Please check the boxes that best indicate your opinion and place the form in the suggestion box. Your responses will help us improve patient services.*

DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Dental Services | Strongly  Agree | Agree | Neutral | Disagree | Strongly Disagree |
| The dental staff was professional, courteous, and friendly. |  |  |  |  |  |
| I was able to receive an appointment within the time I requested. |  |  |  |  |  |
| The dental staff involved me in the decisions about my treatment. |  |  |  |  |  |
| I am satisfied with the treatment provided by the dental staff. |  |  |  |  |  |
| Which dentist did you see today? | | | | | |
| What did you like best about your dental visit? | | | | | |
| What can we do to improve dental services? | | | | | |