**PATIENT SATISFACTION SURVEY**

**WOODROW WILSON KEEBLE MEMORIAL HEALTH CARE CENTER**

**Optometry Department**

*The Optometry 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Optometry Services | Strongly  Agree | Agree | Neutral | Disagree | Strongly Disagree |
| The optometry staff was professional, courteous, and friendly. |  |  |  |  |  |
| I was able to receive an appointment within the time I requested. |  |  |  |  |  |
| The optometry staff gave me time to ask questions and answered them clearly. |  |  |  |  |  |
| I was satisfied with the exam/treatment provided by the optometrist. |  |  |  |  |  |
| What did you like best about your optometry visit? | | | | | |
| What can we do to improve optometry services? | | | | | |