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PATIENT SURVEY

This form is made available for you to give feedback on your experience with this office during your recent procedure. This form is completely anonymous if desired. Please help us serve you better by submitting your comments. **PLEASE MAIL THIS FORM ONLY!**

Name: _____ Date: _____

Please check off your answers to the following questions:

- | | | | |
|--|------------------------------|-----------------------------|---|
| 1. The center was clean and comfortable | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Not Applicable |
| 2. The staff was courteous and professional | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Not Applicable |
| 3. The staff was responsive to my requests | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Not Applicable |
| 4. I received adequate information about financial agreements | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Not Applicable |
| 5. Do you feel your patient confidentiality was maintained at the front desk during admission? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Not Applicable |
| 6. The waiting time for my procedure was appropriate. | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Not Applicable |
| 7. Were you kept informed of any delays? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Not Applicable |
| 8. Do you feel you received clear and complete explanation provided about your procedure? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Not Applicable |
| 9. I was given clear discharge instructions verbally and in writing | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Not Applicable |
| 10. Did you experience adequate pain relief prior to discharge? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Not Applicable |
| 11. Was your pain managed comfortably at home? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Not Applicable |
| 12. Would you recommend our office to family and friends? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Not Applicable |
| 13. Any notable staff? Name: _____ | | | |

Suggestions and Comments:

Thank you for your time😊