Patients Satisfaction Survey

Name ______________________

Nationality ______________________

Date ______________________

When did you visit us for the last time ______________________

What kind of consultation did you have? ______________________

The Doctor name that attended you was ______________________

Are you still coming to ParkwayHealth ? ______________________

1. Please rate your experience on the following scale:

	Excellent	**Very good**	**Good**	**Fair**	**Poor**
Reception Information					
Waiting time					
Nurses treatment					
Doctor treatment					
Pharmacy					
Facilities					
Billing (clear & easy)					
Overall how was your experience with us?					

If you rated any of this items bellow good, can you tell us why:

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Patients Satisfaction Survey

Would you recommend our services/doctors? Why or why not?

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