Painfree Dentistry

PATIENT SURVEY

Thank you for agreeing to complete this feedback/survey. Your participation is voluntary. If you choose not to participate, please return the survey to reception. The quality of the care you receive will not be affected.

The survey is about your experience with this practice. There are no 'right' or 'wrong' answers. It is your opinion that matters to us. This will be completely anonymous. Please DO NOT write your name on the survey. Completion of this survey is taken as prior informed consent.

When completing the survey: Ask your carer, family member or practice staff if you need help completing this form

- Answer all questions by ticking the circles
- If you are unsure, select the answer that is closest to your opinion
- If the item does not apply to you, or if you cannot answer, mark not applicable (N/A)

When you have finished the survey:

- Check that you have answered all questions
- Return the completed survey to reception

PLEASE TICK CIRCLES

ABOUT YOU

1. How long have you been visiting this practice?

O This is my first visit O Less than 1 year O Between 1 and 2 years O Between 2 and 5 years

O Between 5 and 10 years O More than 10 years

2. How many times have you visited this practice over the last year?

O Nil (I haven't visited in the past year O 1 to 2 times O 3 to 5 times O More than 5 times

3. Your age in years

O Less than 18 O 18 to 24 O 25 to 34 O 35 to 44 O 45 to 54 O 55 to 64 O 65 to 74 O 75 years or older

4. Gender

O Female O Male O Prefer to self-describe _____

Scale of 1 to 5 with 1 being *most unlikely* and 5 being most *likely*

	1	**2**	**3**	**4**	**5**
I am able to see the dentist of my choice	O	O	O	O	O
I am able to see a dentist quickly when I need to	O	O	O	O	O
It is easy to make an appointment for a day and time that suits me	O	O	O	O	O
The Reception staff are helpful	O	O	O	O	O
The practice is clean and tidy	O	O	O	O	O
The clinical team paid attention to what I had to say	O	O	O	O	O
The clinical team were caring and concerned about me as a person	O	O	O	O	O
All my questions have been answered	O	O	O	O	O
I received enough information	O	O	O	O	O
Overall I am satisfied with today's service	O	O	O	O	O

Please indicate your likelihood to recommend on the 1 – 10 scale where 1 = Extremely unlikely and 10 = Extremely likely

	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
How likely would you be to recommend this practice to family and friends?	O	O	O	O	O	O	O	O	O	O

What is the best thing about your experience with this practice?

_____

_____

_____

How could this practice improve the quality of care they provide to you?

_____

_____

_____

Comments: _____

_____

_____

_____

Date _____

Thank you for completing this survey, the results will help this practice improve service in the future. If filled out online, please email your completed form to info@painfreedentistry.com.au