Patient Satisfaction Questionnaire

**Name of Dentist: ………………………………………………………………**

Thank you for taking the time to complete this confidential and completely anonymous questionnaire. It will give the dentist named above valuable information about how you feel so that he/she can improve the way they deliver your care.

Please use the 9 point scale (***1 being very poor and 9 being excellent***) to indicate how well you feel the dentist has performed for each statement during your appointment today. If you have time, please add comments in the space provided at the foot of the form.

**Please indicate how well the dentist:**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Development required** | **Satisfactory** | **Outstanding** |
|  | 1 | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** |
| Greeted you and made you feel welcome |  |  |  |  |  |  |  |  |  |
| Helped you feel at ease  |  |  |  |  |  |  |  |  |  |
| Listened to you and to your questions |  |  |  |  |  |  |  |  |  |
| Showed you respect and courtesy |  |  |  |  |  |  |  |  |  |
| Explained treatment choices clearly and thoroughly to you in terms you understood |  |  |  |  |  |  |  |  |  |
| Communicated costs of treatment well and appropriately |  |  |  |  |  |  |  |  |  |
| Gave you time to think and ask questions |  |  |  |  |  |  |  |  |  |
| Answered any questions you had |  |  |  |  |  |  |  |  |  |

**Please also indicate:**

How confident you felt with the dentist:

To what degree the appointment felt/did not feel rushed:

Would you recommend the dentist to a friend or member of your family YES NO

Did you feel discriminated against in any way YES NO

Please add comments below: