Patient Satisfaction Survey

At the New England Eye Center, we realize that the most important outcome of any procedure is patient satisfaction.

We would like to know about your personal experience and hope you will take the time to fill out this survey for us.

	5 High	4	3	2	1 Low
Initial telephone contact with our practice:	☐	☐	☐	☐	☐
Appearance of facility:	☐	☐	☐	☐	☐
Patient education process:	☐	☐	☐	☐	☐
Patient education materials:	☐	☐	☐	☐	☐
Knowledge of staff:	☐	☐	☐	☐	☐
Courtesy of staff:	☐	☐	☐	☐	☐
Availability of appointments:	☐	☐	☐	☐	☐
Waiting time during visits:	☐	☐	☐	☐	☐
Surgical experience:	☐	☐	☐	☐	☐
Payment options:	☐	☐	☐	☐	☐
Overall experience:	☐	☐	☐	☐	☐

Please add any additional comments you may have about your experience:

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We would be happy to provide information to any friends or family members you believe would benefit from LASIK. If you would recommend our service to others please identify them below. We will only contact them if you indicate to do so.

Name: ________________________________

Address: ______________________________

City: ___________ State: ___ Zip: _______

Daytime Phone: ________________________

Email Address: ________________________

Would you like us to send an information packet?
Yes / No

Okay to invite to a free consultation? Yes / No

Name:__________________________________

Address:_______________________________

City: _______________ State: ____ Zip: _______

Daytime Phone:____________________________

Email Address: ____________________________

Would you like us to send an information packet?
Yes / No

Okay to invite to a free consultation? Yes / No

Name: ________________________________

Address: ______________________________

City: ___________ State: ___ Zip: _______

Daytime Phone: ________________________

Email Address: ________________________

Would you like us to send an information packet?
Yes / No

Okay to invite to a free consultation? Yes / No

Name:__________________________________

Address:_______________________________

City: _______________ State: ____ Zip: _______

Daytime Phone:____________________________

Email Address: ____________________________

Would you like us to send an information packet?
Yes / No

Okay to invite to a free consultation? Yes / No

Patient Name
(Optional):____

Thank you again for your time in filling out this information.
We hope that we can service you or your family again in the future!