Email Form Print

EASTERN PENNSYLVANIA GASTROENTEROLOGY AND LIVER SPECIALISTS

Patient Satisfaction Survey

Name (Optional): _____ **Date:** _____

Are you male or female? ◯ Male ◯ Female **Provider Seen:** _____

Current Age: _____

To Our Patients:

We value our patients and are interested in receiving feedback about the care provided at our office. Please take a few moments to complete this survey and return it to us. Your responses are important to us and will help improve the quality of care we provide to our patients.

How satisfied were you with the following?

	Poor	Fair	Good	Very Good	Excellent
Ease of scheduling an appointment:	◯	◯	◯	◯	◯
Convenience of the location of our office(s):	◯	◯	◯	◯	◯
Ease of speaking to staff via telephone:	◯	◯	◯	◯	◯
Ease of obtaining medical information (test results, instructions, med refills, etc.):	◯	◯	◯	◯	◯
Wait time in the office:	◯	◯	◯	◯	◯
Time spent with your Provider:	◯	◯	◯	◯	◯
Explanation of care given:	◯	◯	◯	◯	◯
Technical skill of Provider you saw:	◯	◯	◯	◯	◯
The personal manner (courtesy, respect, sensitivity, friendliness) of the staff:	◯	◯	◯	◯	◯
Would you recommend our practice to a friend or family member?	◯	◯	◯	◯	◯
What is your overall satisfaction with EPGI:	◯	◯	◯	◯	◯

	Very Unlikely	Unlikely	Neutral	Likely	Very Likely
Would you recommend our practice to a friend or family member?	◯	◯	◯	◯	◯

We sincerely value your opinion and feedback. Please provide us with any additional information that you wish to share (please use the back if more space is required):

By signing below, I am authorizing EPGI to reprint, reproduce, or use my testimonial in connection with our organization. If you are completing this online, then typing your name is equivalent to a hand written signature.

Name: _____ **Date:** _____ (optional)

(Information provided may appear on the practice website. Last name will not be displayed)