Rosebud Dental Group

PATIENT FEEDBACK SURVEY

We value your feedback to assist us to improve the services we provide. Please complete the questions below by placing a rating in the relevant response box.

This form is anonymous, however you are welcome to put your name at the end if you would like us to follow up any of your concerns.

How long have you been a patient at this practice? _____

Please rate the following accordingly

6-Excellent 5-Very Good 4-Good 3-Average 2-Fair 1-Poor

The service provided by our receptionists _____

The treatment and clinical knowledge of our dentists _____

The treatment and clinical knowledge of our dental nurses _____

The quality of communication from our dentists _____

The dentist explaining dental care, alternative treatments and costs _____

The ability to obtain an appointment at our clinic _____

The facilities at our clinic _____

The waiting room _____

Parking and access _____

The overall cleanliness of our clinic _____

Your overall experience at Rosebud Dental Group _____

	Y	N
Would you recommend our clinic to others?	☐	☐

Do you have any further comments to make?

_____

_____

_____

_____

_____

_____

Date ___/___/___ Name (Optional) _____