Hampton Roads Gastroenterology, PC

PATIENT QUESTIONNAIRE

Patient Name: (OPTIONAL)________________________________Date:______________ Date of Service:______________

In our efforts to make your experience with us the best possible, we ask that you take a few moments to complete this short questionnaire.

Please respond by circling the number that best describes your experience with us:

1=poor - 5=excellent

1. The facility was clean	*1*	*2*	*3*	*4*	*5*
2. I was provided with adequate privacy	*1*	*2*	*3*	*4*	*5*
3. The staff was professional and courteous	*1*	*2*	*3*	*4*	*5*
________) *4. I would recommend this practice to my family and friends*	*1*	*2*	*3*	*4*	*5*
5. Please rate the care of your anesthesia team	*1*	*2*	*3*	*4*	*5*

Would you return to our office? YES NO

How would you rate your overall experience with us for this visit? 1 2 3 4 5

Revised 1/2015