



PATIENT SATISFACTION QUESTIONNAIRE

Please help us improve the quality of our services by taking a moment to complete this survey. Please fold and mail when completed the address is provided on the back.

I learned about Pacific Hills Surgery Center, LLC from: Physician Family/Friends
 Other _____

	EXCELLENT	GOOD	FAIR	POOR	NA
1. Did we call a day in advance to confirm your surgery date/time?	4	3	2	1	0
2. When I arrived at Pacific Hills Surgery Center, I was treated courteously and was taken care of promptly. How long was your wait in the reception area? _____min.	4	3	2	1	0
3. During my stay the staff was concerned for my comfort, care and privacy. All forms and procedures were explained.	4	3	2	1	0
4. All of the forms and procedures were explained to me by staff.	4	3	2	1	0
5. The staff answered my questions and kept me informed.	4	3	2	1	0
6. How would you rate the care you received from Anesthesia?	4	3	2	1	0
7. How would you rate the care you received from your Surgeon?	4	3	2	1	0
8. How would you rate understanding of your post-op instructions?	4	3	2	1	0

9. What suggestions can you make to help us better serve our future patients? _____

10. What services did you most appreciate? _____

11. Did you have any problems after surgery? _____

12. Additional comments? _____

Thank you

Date of Procedure _____ Name(optional) _____