

## Dental Patient Satisfaction Survey

Please help us improve your care. Fill the checkboxes completely using a blue or black pen. Your answers are anonymous and confidential.

### Your experience at our practice

**How satisfied were you with each of the following?**

*Please cross one in each line*

Ease of booking your appointment  
Waiting time  
The hygienist  
Communication from the dentist  
Comfort and pain management  
Value for money  
Cleanliness of the practice

| Very dissatisfied     | Dissatisfied          | Neutral               | Satisfied             | Very satisfied        |
|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
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| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

### Recommending us

**How likely are you to recommend our practice?**

*(Please cross one)*

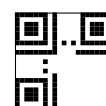
- ☐ Very likely  
☐ Likely  
☐ Neutral  
☐ Unlikely  
☐ Very unlikely

### Anything else

**Any other comments?**

Thank you for your feedback. Please return this form to the reception desk.

To respond ☒ or ☐



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