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Patient Satisfaction Survey

Please take a few minutes to fill out this survey on the timeliness and the quality of the service(s) you received. We at West Ridge Obstetrics & Gynecology welcome your feedback and all your answers will be kept confidential. Thank you for your participation.

YOUR APPOINTMENT WAS WITH: Physician Nurse Practitioner Nurse Sonographer DXA Technologist

YOUR APPOINTMENT WAS IN THE: Greece Office Webster Office

PLEASE RATE THE FOLLOWING:

	Excellent	Very Good	Good	Fair	Poor	Does Not Apply
A. YOUR APPOINTMENT:						
1. Ease of making appointments by phone	5	4	3	2	1	N/A
2. Appointment available within a reasonable amount of time	5	4	3	2	1	N/A
3. Getting care of illness/injury as soon as you wanted it	5	4	3	2	1	N/A
4. Getting after-hours assistance when you needed it	5	4	3	2	1	N/A
5. The efficiency of the check-in process	5	4	3	2	1	N/A
6. Waiting time in the reception room	5	4	3	2	1	N/A
7. Waiting time in the exam room	5	4	3	2	1	N/A
8. Keeping you informed if your appointment time was delayed	5	4	3	2	1	N/A
B. OUR STAFF:						
1. The courtesy of the person who took your call	5	4	3	2	1	N/A
2. The friendliness and courtesy of the receptionist	5	4	3	2	1	N/A
3. The caring concern of our nurses/medical assistants	5	4	3	2	1	N/A
4. The helpfulness of the people who assisted you with billing or insurance	5	4	3	2	1	N/A
C. OUR COMMUNICATION WITH YOU:						
1. Your phone calls answered promptly	5	4	3	2	1	N/A
2. Getting advice or help when needed during office hours	5	4	3	2	1	N/A
3. Explanation of your procedure (if applicable)	5	4	3	2	1	N/A
4. Your test results reported in a reasonable amount of time	5	4	3	2	1	N/A
5. Effectiveness of our health information materials	5	4	3	2	1	N/A
6. Our ability to return your calls in a timely manner	5	4	3	2	1	N/A
7. Your ability to contact us after hours for urgent concerns	5	4	3	2	1	N/A
8. Your ability to obtain prescription refills by phone	5	4	3	2	1	N/A

PLEASE COMPLETE THE OTHER SIDE

	Excellent	Very Good	Good	Fair	Poor	Does Not Apply
D. YOUR VISIT WITH THE PROVIDER: (Doctor, Nurse Practitioner, Nurse or Other)						
1. Willingness to listen carefully to you	5	4	3	2	1	N/A
2. Taking time to answer your questions	5	4	3	2	1	N/A
3. Quality of time spent with you	5	4	3	2	1	N/A
4. Explaining things in a way you could understand	5	4	3	2	1	N/A
5. Instructions regarding medication/ follow-up care	5	4	3	2	1	N/A
6. The thoroughness of the examination	5	4	3	2	1	N/A
7. Advice given to you on ways to stay healthy	5	4	3	2	1	N/A
E. OUR FACILITY:						
1. Hours of operation convenient for you	5	4	3	2	1	N/A
2. Overall comfort	5	4	3	2	1	N/A
3. Adequate parking	5	4	3	2	1	N/A
4. Signage and directions easy to follow	5	4	3	2	1	N/A
F. YOUR OVERALL SATISFACTION WITH:						
1. Our practice	5	4	3	2	1	N/A
2. The quality of your medical care	5	4	3	2	1	N/A
3. Overall rating of care from your provider or nurse	5	4	3	2	1	N/A

Would you recommend the provider to others?

YES

NO

If NO, please tell us why: _____

What other services would you like to see us provide? _____

If there is any way we can improve our services to you, please tell us about it: _____

Information about you: (optional)

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____

Your Age:

Under 18

18-30

31-40

41-50

51-60

Over 60

Are You a:

New patient

Returning patient

Do you want to be contacted regarding your responses on this survey?

YES

NO

Thank you for taking the time to fill out our survey. We rely on our patient's feedback to help us improve our services to you. Your input is greatly appreciated.