DERMATOLOGY
Center of Richmond

Dermatology Center of Richmond, P.C.
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Patient Questionnaire

In an effort to assure quality patient care in our facility, we would appreciate your completing the following questionnaire and returning it to us.

YES	NO		
❑	❑	1.	Were our phones answered quickly and professionally?
❑	❑	2.	If you were on hold, was the hold time reasonable?
❑	❑	3.	Were you provided with insurance information, appointment information, and instructions to the office when you called our office?
❑	❑	4.	Were you greeted promptly and courteously upon your arrival to our office?
❑	❑	5.	Did you find our forms easy to complete?
❑	❑	6.	Did you find the forms too lengthy?
❑	❑	7.	Was the staff helpful and courteous during the check-in process?
❑	❑	8.	Was the staff helpful and courteous during your check-out process?
❑	❑	9.	If you had a copayment or deductible, was the reason for the amount you had to pay explained to you in a satisfactory manner?
❑	❑	10.	Were all your insurance questions answered competently and politely?
❑	❑	11.	Did the Physician discuss your condition/procedure to your satisfaction?
❑	❑	12.	Were you well-informed of the date and time of your appointment?
❑	❑	13.	Did the appointment begin at the scheduled time?
❑	❑	14.	Was the environment comfortable, organized and clean?
❑	❑	15.	Did the nursing staff make themselves available to answer your questions and explain procedures?
❑	❑	16.	Did you receive your prescriptions (if any) as discussed during the exam?

❑ ❑ 17. Were there any problems you did not anticipate?

Explain: _____

_____

18. Which did you and your family find most informative?
❑ Staff members ❑ Brochures ❑ Web site

19. On the day of your visit:

a. What did you like best? _____

b. What did you like least? _____

20. How might we improve? _____

Please Rate the Following

Excellent	Average	Deficient		
_____	_____	_____	1.	Courtesy of the Staff
_____	_____	_____	2.	Professionalism of the Staff
_____	_____	_____	3.	Efficiency of the Staff
_____	_____	_____	4.	Clarity of Instructions Given
_____	_____	_____	5.	Effectiveness of Post-operative Teaching
_____	_____	_____	6.	Explanation of Costs and Insurance Coverage

Date of Office Visit: ____ /____/ ____

Name (Optional):_____

Thank you for your comments.
Please return questionnaire to the office.