PATIENT SATISFACTION SURVEY

Thank you for completing this brief survey. Our goal is for you to be completely satisfied with the services you receive from us. Your comments and suggestions will be greatly appreciated, and will help us to further improve the services that we provide for you and your family.

1. Was the staff courteous and friendly?
   Yes No

2. Were you seen in a timely manner?
   Yes No

3. Was your examination thorough?
   Yes No

4. Were you satisfied with the doctor's explanation of your visual conditions?
   Yes No

5. Were your vision/eye problems solved?
   Yes No Does Not Apply

6. If eye medicine was prescribed, did it eliminate your symptoms?
   Yes No Does Not Apply

7. Were you satisfied with the contact lens services and contact lenses you received?
   Yes No Does Not Apply

8. Were you satisfied with our selection of eyeglass frames?
   Yes No Does Not Apply

9. Were you satisfied with the help you received in the selection and fitting of your new eyeglasses?
   Yes No Does Not Apply

10. Do you feel that you received excellent value in your eyewear and eye care services?
    Yes No Does Not Apply

11. Who is your doctor? Dr. Storhaug Dr. Gander Dr. Coles

12. Would you recommend us to your friends and family?
    Yes No

Comments or suggestions: _____

_____

_____

Opticare (Check location seen)
_____ Crookston
_____ East Grand Forks

Your Name (Optional)
_____