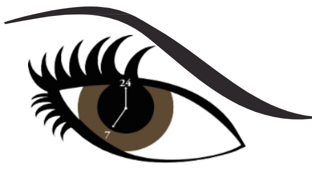

24/7 Vision & EYE CARE **DATE:_________________**

"Clear Sight All Day, Everyday"

Satisfaction Survey

Please take a moment and let us know what you thought of your visit today

Provider:

Dr. Malkishuana Lacy

Service Rating	**Great**	Good	Fair	Poor	N/A
Communication prior to appointment	◯	◯	◯	◯	◯
Appointment availability	◯	◯	◯	◯	◯
Waiting room time	◯	◯	◯	◯	◯
Fees	◯	◯	◯	◯	◯
Quality of care from staff	◯	◯	◯	◯	◯
Quality of care from doctor	◯	◯	◯	◯	◯
Concerns or questions answered	◯	◯	◯	◯	◯
Overall quality of care	◯	◯	◯	◯	◯

Scheduling

Preferred day for appointments: ______________________________________

Preferred time for appointments: _____________________________________

Do you plan on returning for your next comprehensive examination? ◯ **Yes** ◯ No

For no, please tell us why not: ____
____
____

Would you schedule appointments online? ◯ **Yes** ◯ No

Identification (Optional)

Why did you choose us for your eye health care? ____
____

Your name (optional) ____