DREXEL HILL PEDIATRIC ASSOCIATES
Patient Satisfaction Survey

Dear Parent / Guardian
How are we doing? We want to know! Please take a few minutes of your time to help us. Our goal is to provide comfort, convenience and satisfaction as well as the best medical care to our patients and families. We are using this survey to help improve our access, scheduling and service. Drop completed survey in box near our front desk or complete via our website (www.drexelhillpeds.com).

Today's date: _____

Type of visit: ☐ Sick Visit ☐ Well Visit ☐ Other_____

How old is your child? _____ Is your child: ☐ male or ☐ female

Do you know we have a website and patient portal? ☐ Yes ☐ No Do you use it? ☐ Yes ☐ No

What doctor/nurse practitioner does your child usually see?

- ☐ Dr Soppas, MD
- ☐ Dr Warner, DO
- ☐ Dr Browngoehl, MD
- ☐ Dr Johnson, MD
- ☐ Dr Advani, MD
- ☐ Dr Jain, MD
- ☐ Dr Uy, DO
- ☐ Dr Rollnik, MD
- ☐ Dr McCarthy, MD
- ☐ Dr Kostelnik, MD
- ☐ Dr Rubin, MD

What doctor/nurse practitioner did your child see for this most recent visit?

- ☐ Dr Soppas, MD
- ☐ Dr Warner, DO
- ☐ Dr Browngoehl, MD
- ☐ Dr Johnson, MD
- ☐ Dr Advani, MD
- ☐ Dr Jain, MD
- ☐ Dr Uy, DO
- ☐ Dr Rollnik, MD
- ☐ Dr McCarthy, MD
- ☐ Dr Kostelnik, MD
- ☐ Dr Rubin, MD

Please rate the following:

A. YOUR APPOINTMENT:	**Excellent**	**Very Good**	**Good**	**Fair**	**Poor**	**N/A**
1. Ease of making appointments by phone	☐	☐	☐	☐	☐	☐
2. Appointment available within a reasonable amount of time	☐	☐	☐	☐	☐	☐
3. Getting care for illness/injury as soon as you needed it	☐	☐	☐	☐	☐	☐
4. Getting after-hours care when you needed it	☐	☐	☐	☐	☐	☐
5. Waiting time in the reception room	☐	☐	☐	☐	☐	☐
6. Waiting time in the exam room to see your provider	☐	☐	☐	☐	☐	☐
7. Ease of getting a referral when you needed one	☐	☐	☐	☐	☐	☐
8. Ease of using patient portal for appointment request	☐	☐	☐	☐	☐	☐
B. OUR STAFF:						
1. The friendliness and courtesy of the receptionist	☐	☐	☐	☐	☐	☐
2. The concern and knowledge of our phone nurses	☐	☐	☐	☐	☐	☐
3. The care of clinical staff who escorted you to exam room	☐	☐	☐	☐	☐	☐

PLEASE COMPLETE THE OTHER SIDE →

C. OUR COMMUNICATION WITH YOU:	Excellent	Very Good	Good	Fair	Poor	N/A
1. Waiting time to speak with phone nurse	☐	☐	☐	☐	☐	☐
2. Getting advice or help when needed during office hours	☐	☐	☐	☐	☐	☐
3. Your test results reported in a reasonable amount of time	☐	☐	☐	☐	☐	☐
4. Our ability to return calls in a timely manner (by nurse)	☐	☐	☐	☐	☐	☐
5. Our ability to return calls in a timely manner (by Doctor)	☐	☐	☐	☐	☐	☐
6. Our response time for prescription refill requests	☐	☐	☐	☐	☐	☐

D. YOUR VISIT WITH THE DOCTOR:

1. Willingness to listen carefully to you/your child	☐	☐	☐	☐	☐	☐
2. Taking time to answer your questions	☐	☐	☐	☐	☐	☐
3. Explaining things in a way you could understand	☐	☐	☐	☐	☐	☐
4. Instructions regarding medication/follow-up care	☐	☐	☐	☐	☐	☐
5. Advice given to you on ways to stay healthy	☐	☐	☐	☐	☐	☐

E. OUR FACILITY:

1. Hours of operation convenient for you	☐	☐	☐	☐	☐	☐
2. Overall comfort	☐	☐	☐	☐	☐	☐
3. Adequate parking	☐	☐	☐	☐	☐	☐
4. Signage and directions easy to follow	☐	☐	☐	☐	☐	☐

F. YOUR OVERALL SATISFACTION WITH:

1. Our practice	☐	☐	☐	☐	☐	☐
2. The quality of your medical care	☐	☐	☐	☐	☐	☐
3. Overall rating of care from your Doctor or nurse	☐	☐	☐	☐	☐	☐
4. Are our community resources appropriate for your needs	☐	☐	☐	☐	☐	☐

WOULD YOU RECOMMEND OUR OFFICE TO OTHERS? ☐ YES ☐ NO

IF YES, TELL US WHY (WAS THERE ANYONE WHO WAS OF PARTICULAR HELP TO YOU TODAY?) AND IF NO, PLEASE TELL US WHY. _____

IS THERE ANYTHING WE COULD IMPROVE? PLEASE TELL US ABOUT IT. _____

_____

Optional: Your name: _____ Patient's name: _____

Would you mind if someone contacted you regarding this survey? ☐ Yes ☐ No What would be the best phone number to contact you? _____