



## Thank You

On behalf of Winnetka Endodontics, we would like to thank you for taking the time to complete the Patient Comment Card. Your opinions and feedback are invaluable to us.

After completing the form, please save the file to your desktop and return to us using any one of the following methods:

### EMAIL

Email the document to **[info@winnetkaendodontics.com](mailto:info@winnetkaendodontics.com)**

### MAIL

Print the completed document and mail to:

**Winnetka Endodontics**  
**585 Lincoln Avenue**  
**Winnetka, Illinois 60093**

### FAX

Print the completed document and fax to **847.446.6187**



**PATIENT COMMENTS**

We hope that you have had a comfortable and pleasant experience in our office. We would greatly appreciate it if you would take a moment to share your impressions of our practice. We are always striving to provide you outstanding service and your feedback helps us do that.

	Excellent	Satisfactory	Unacceptable
1. Your overall experience in our office	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Flexibility in arranging appointments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Handling your phone calls and scheduling your treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Explanation of treatment procedures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Our respect of your time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Courteousness & concern of receptionists	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Courteousness & concern of chairside asst.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Courteousness & concern of doctor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Professionalism & gentleness of chairside asst.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Professionalism & gentleness of doctor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. The quality of services we provided	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. The value of services we provided	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

13. Would you recommend our office?      Yes       No

14. We would appreciate any comments you have about your experience in our office.

If you wrote a comment, would you be willing to let us use your first name and comments in print for our office information?      Yes       No

Name (optional) \_\_\_\_\_

Referring Doctor name (optional) \_\_\_\_\_