

Thank you for taking the time to complete the following questionnaire. Please circle, check, or fill in your responses. Return it in the enclosed self-addressed, stamped envelope.

What procedure(s) did you have performed during your most recent surgery?

explant, lip and fat transfer

How would you rate your experience? Excellent 10...9...8...7...6...5...4...3...2...1 Poor

Would you recommend our practice to your friends?

Yes

No

Uncertain

What was the best part of your consult?

Dr Rodriguez and staff are wonderful, thorough and honest consult

Why did you select Dr. Rodriguez and our office for your surgery?

Several friends recommended

What else could we have done to help you prepare for your surgery?

How was your experience with the anesthesiologist?

good

Please indicate your experience in the recovery room?

Duration of room time Too Short Too Long Adequate

Temperature Too Short Too Long Adequate

My Pain Management Too Short Adequate Adequate

Other, please explain:

Would you return to this office if you decide to have additional surgery? Yes , No Uncertain

Which of the following factors influenced you to choose Dr. Rodriguez?

(check all that apply)

- | | | |
|---|---|--|
| <input checked="" type="checkbox"/> Reputation of doctor | <input type="checkbox"/> Phone book ad | <input checked="" type="checkbox"/> Recommendation by friend or family |
| <input checked="" type="checkbox"/> Board certification, Training | <input type="checkbox"/> News article/show | <input type="checkbox"/> Recommendation by salon staff |
| <input checked="" type="checkbox"/> Technology used | <input type="checkbox"/> Print ad in: _____ | <input checked="" type="checkbox"/> Cost of surgery |
| <input checked="" type="checkbox"/> Procedures offered | <input type="checkbox"/> Seminar appearance | <input type="checkbox"/> Financing options |
| <input type="checkbox"/> Internet web page | <input type="checkbox"/> Hospital referral | <input type="checkbox"/> Friendly staff |
| <input type="checkbox"/> Location of office | <input type="checkbox"/> Physician referral | <input type="checkbox"/> Other: _____ |

Were your telephone calls to our office handled to your satisfaction?

Yes

No

Comments:

