ORAL SURGERY ASSOCIATES
Specialists in Oral & Maxillofacial Surgery

We strive to provide the very best patient care. We ask for your feedback and input to help us in continuing with our practice improvement. Your candid suggestions are welcome and will be kept confidential. Thank you in advance for your assitance.

1 Which our of surgeons do you routinely refer to? (check all that apply)

◯ Andersen ◯ Auch ◯ Coffey ◯ Engel ◯ Heit ◯ Marshall
◯ Pfeifle ◯ Schneider ◯ Sears ◯ Wendt ◯ Wood

2 How do you determine who send your oral surgery cases to? (check all that apply)

◯ Reputation for quality care ◯ Location-close to home/office ◯ Insurance network
◯ Relationship with surgeon ◯ Other (please explain) _____

3 What is the single most important change related to patient care that we cold do to improve your satisfaction with our service?

4 What is the single most common challenge your patients have with our practice?

5 What can we do to improve our relationship with your office?

REFERRAL PROCESS	VERY GOOD	GOOD	FAIR	POOR	VERY POOR
1 Your office's ease of scheduling patient's appointment	◯	◯	◯	◯	◯
2 Courtesy/Friendliness of person who scheduled the appointment	◯	◯	◯	◯	◯
3 Communication between offices	◯	◯	◯	◯	◯
4 Our helpfulness on the telephone	◯	◯	◯	◯	◯
5 Our promptness in returning your phone calls	◯	◯	◯	◯	◯
6 Appointment scheduled in a reasonable time	◯	◯	◯	◯	◯
7 Our willingness to see urgent cases on short notice	◯	◯	◯	◯	◯

8 Does your office have an interest in using an online collabaration tool to communicate on cases?

◯ Yes ◯ No

9 What do you feel we need to **do better** to make the referral process better?

PATIENT CARE	VERY GOOD	GOOD	FAIR	POOR	VERY POOR
1 Care patients feel they receive from our office	◯	◯	◯	◯	◯
2 The clinical skills of our doctors	◯	◯	◯	◯	◯
3 Thoroughness of patient status reports	◯	◯	◯	◯	◯
4 Inclusion of your in the follow-up care of your patient	◯	◯	◯	◯	◯
5 The process of returning your patient to your care	◯	◯	◯	◯	◯
6 Our practice locations convenient for your patients	◯	◯	◯	◯	◯

Referral Name: *(optional)* _____