[Company name]

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Dental practice patient feedback form

Date of visit	[Date]

Your experience

Question	Answer / rating
Was your pain managed well during treatment? (1–5)	
Was the treatment explained clearly beforehand? (1–5)	
How comfortable did you feel? (1–5)	
How was the waiting time? (1–5)	
How would you rate the overall experience? (1–5)	
Would you recommend us to others?	

Comments

[Anything else you would like to tell us]

Contact (optional)

Phone	[Phone]
Email	[Email]