Pediatric Associates of Alexandria, Inc.

Patient Survey

Patient's Name: ______________________________ **Date Of Your Visit:**______________
(optional)

1. Customer service is very important to PAA, how do you feel you and your family were treated today?____
   ____

2. How would you compare PAA to other pediatric practices?
   (Circle One) Better Worse Same ____________________________________
   ____

3. What could we have done to make your visit more pleasant?
   ____
   ____

4. Have you had any interaction with our billing department?
   (Circle One) Yes No
   Was it (circle one) Good Bad Indifferent
   ____
   ____

5. Would you recommend PAA to a friend/family?
   (Circle One) Yes No
   ____
   ____

6. Did any staff member(s) exceed your expectation today?
   (Circle One) Yes No If so who? ____________________________________
   ____

7. Did you have a scheduled appointment or did you walk in to be seen?
   (Circle One) Walk in Appointment

Comments/Suggestions:
____
____

--(FOLD)--

Patient Survey

-- (FOLD)--

Place
Stamp
Here

Pediatric Associates of Alexandria
6355 Walker Lane, Suite 401
Alexandria, Virginia 22310

ATTN: Practice Administrator