

**Your practice
logo here**

New Patient Consultation/Dental Assessment Feedback Form

Dear Patient,

Thank you for choosing **DENTAL PRACTICE** for your new patient consultation/dental assessment.

We believe exceptional dental care begins with trust, clear communication and a personalised approach. Our dedicated team is committed to ensuring you feel welcome, listened to and confident in the care and recommendations you receive.

Your experience is incredibly important to us, and we are always looking for ways to improve. We would therefore be grateful if you could take a few moments to complete this feedback form and share your thoughts on your visit.

We genuinely value your feedback, which helps us continually improve the care and experience we provide for our patients.

■ **About your visit**

Date of visit: _____ Dentist seen: _____

■ **Your welcome and first impressions**

How welcoming and friendly did you find our reception team?

☐ Excellent ☐ Good ☐ Satisfactory ☐ Needs improvement

Did you feel comfortable and at ease in the practice?

☐ Yes, completely ☐ Mostly ☐ Not really

■ **Your clinical experience and communication**

Did the dentist clearly explain:

The health of your teeth?

☐ Yes ☐ Partly ☐ No

The health of your gums?

☐ Yes ☐ Partly ☐ No

Did you feel your dentist understood the following:

Any concerns you had about your teeth or dental health?

- ☐ Yes, completely ☐ Mostly ☐ Not really

Any changes you would like to make to your smile?

- ☐ Yes, completely ☐ Mostly ☐ Not really ☐ Not applicable

Did you feel you had enough time to:

Talk through your concerns?

- ☐ Yes ☐ Mostly ☐ No

Discuss any recommendations and the next steps in your dental care?

- ☐ Yes ☐ Mostly ☐ No

Did you feel able to ask questions?

- ☐ Yes ☐ Somewhat ☐ No

■ **The dental team experience**

Was your dental nurse introduced to you by name?

- ☐ Yes ☐ No ☐ I'm not sure

How well supported did you feel by your dental nurse during your appointment?

- ☐ Very well supported ☐ Well supported ☐ Somewhat supported ☐ Not supported

Did you feel listened to and respected by the clinical team?

- ☐ Yes ☐ Mostly ☐ No

■ **Confidence and trust**

Following your appointment, how confident do you feel about your dental health?

- ☐ Very confident ☐ Fairly confident ☐ Not confident

■ **Treatment co-ordination**

Did you meet or speak with a Treatment Co-ordinator during your visit?

- ☐ Yes, in person ☐ Yes, by phone or video
☐ No (skip to Overall Experience) ☐ I'm not sure

If you spoke with a Treatment Co-ordinator, which of the following did they help you with? (Please tick all that apply.)

- ☐ Understand your treatment options ☐ Understand the costs involved
☐ Understand the stages of treatment ☐ Feel more confident about your decisions
☐ Get answers to your questions
-

Did speaking with the Treatment Co-ordinator help you gain a clearer understanding of your treatment options?

☐ Yes, much clearer ☐ A little clearer ☐ No difference

How helpful did you find the Treatment Co-ordinator?

☐ Extremely helpful ☐ Helpful ☐ Somewhat helpful ☐ Not helpful

Did you feel you had enough time to discuss your questions and concerns?

☐ Yes, definitely ☐ Yes, mostly ☐ No

What did you find most helpful about speaking with the Treatment Co-ordinator?

Is there anything that could have improved this part of your experience?

■ Overall experience

Overall, how would you rate your new patient experience?

☐ Excellent ☐ Good ☐ Satisfactory ☐ Needs improvement

Has your first visit given you confidence in continuing your dental care with our practice?

☐ Yes, definitely ☐ Yes, mostly ☐ Not sure ☐ No

What did we do particularly well during your visit?

Is there anything we could improve?

■ Would you like us to contact you about your feedback?

All feedback is reviewed carefully and helps us improve patient care.

If you would like our Practice Manager to contact you personally regarding your feedback, please complete the section below and we will aim to contact you as soon as possible.

Name: _____

Preferred contact method: ☐ Telephone ☐ Email

Telephone number/Email Address: _____

■ Testimonial

If you have had a positive experience with us, we would be delighted if you could share a testimonial about your first visit and the care you received.

With your permission, we may share your comments on our website, social media channels and other marketing materials to help others learn more about the care and experience we provide. Your testimonial will only be shared with your consent, which you may withdraw for future use at any time by contacting the practice.

☐ I consent to **DENTAL PRACTICE** using my testimonial for marketing purposes, including on its website, social media channels and printed promotional materials. I understand that I can withdraw my consent for future use at any time by contacting the practice.

■ Thank you

Thank you for taking the time to share your experience with us.

We genuinely appreciate your feedback, which helps us continually improve our services and maintain the highest standards of patient care.

We look forward to welcoming you again at your next appointment.

The Team at DENTAL PRACTICE
