

**Your practice
logo here**

Treatment Experience Feedback Form

Dear Patient,

Thank you for choosing to have your treatment with us at **DENTAL PRACTICE**.

We understand that choosing to undergo dental treatment is an important decision, and we want you to feel informed, comfortable and supported at every stage.

Our dentists, dental nurses and wider practice team work together to ensure you receive the highest standards of care. Your honest feedback helps us recognise what we do well and identify where we can improve. We would be grateful if you could take a few minutes to complete this form.

■ **About your visit**

Date of appointment: _____ Dentist: _____

Dental Nurse: _____ Treatment received: _____

■ **Your welcome and experience**

How welcoming and friendly did you find our reception team?

☐ Excellent ☐ Good ☐ Satisfactory ☐ Needs improvement

Did you feel comfortable and at ease when you arrived at the practice?

☐ Yes, completely ☐ Mostly ☐ Not really

■ **Understanding your treatment**

Were your treatment options explained clearly before treatment began?

☐ Yes, completely ☐ Mostly ☐ Not really

Were the potential benefits and risks of your treatment explained in a way you could easily understand?

☐ Yes, completely ☐ Mostly ☐ Not really

Did you feel you had enough time to ask questions and discuss concerns before deciding to proceed with treatment?

☐ Yes ☐ To some extent ☐ No

If other team members, such as your dental nurse or treatment coordinator, helped explain your care, did you find their support helpful?

- ☐ Yes, completely ☐ Mostly ☐ Not really

■ Your experience during treatment

Did you feel well cared for throughout your treatment?

- ☐ Yes, completely ☐ Mostly ☐ Not really

Did your dental nurse provide reassurance and support throughout your treatment?

- ☐ Yes, completely ☐ Mostly ☐ Not really

Did your dental nurse help you feel comfortable and at ease?

- ☐ Yes, a great deal ☐ Somewhat ☐ Not really

Did you feel your dentist and dental nurse worked well together as a team?

- ☐ Yes, very well ☐ Mostly ☐ Not really

How comfortable were you during treatment?

- ☐ Very comfortable ☐ Comfortable ☐ Somewhat comfortable ☐ Not comfortable

Was your dental nurse introduced to you by name?

- ☐ Yes ☐ No ☐ Not sure

Did you experience any discomfort or pain during your treatment?

- ☐ No ☐ Mild ☐ Moderate ☐ Significant

If you experienced any discomfort or pain, did the dental team respond promptly and help you feel more comfortable?

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

Did you feel listened to and respected by your dentist?

- ☐ Yes ☐ Mostly ☐ No

■ Treatment outcome and confidence

How do you feel about the outcome of your treatment so far?

- ☐ Very pleased ☐ Pleased ☐ Unsure ☐ Not satisfied

Has the outcome met the expectations discussed with you?

- ☐ Yes, completely ☐ Mostly ☐ Not really ☐ Too early to say
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Do you feel more confident about your dental health or smile following treatment?

- ☐ Yes, a great deal ☐ Somewhat ☐ Not really ☐ Too early to say

■ Aftercare and support

Were you given clear advice on how to care for your teeth following treatment?

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

Do you understand the next steps, including any follow-up appointments or further treatment?

- ☐ Yes ☐ Somewhat ☐ No ☐ Not applicable

■ Value and decision-making

Do you feel the treatment and care you received represented good value for money?

- ☐ Yes, completely ☐ Mostly ☐ Not sure

Did you feel supported in making the treatment decision that was right for you?

- ☐ Yes, completely ☐ Mostly ☐ Not really

■ Overall experience

Overall, how would you rate your experience of receiving treatment at our practice?

- ☐ Excellent ☐ Good ☐ Satisfactory ☐ Needs improvement

Would you recommend our practice to friends or family?

- ☐ Definitely ☐ Probably ☐ Not sure ☐ No

■ Your feedback

What did we do particularly well?

What could we do better?

■ 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 treatment experience with us, we would be delighted if you could share a testimonial about the care you received and your treatment journey.

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
