



MIDWEST

NEUROSURGEONS, LLC

SONJAY JOSEPH FONN, DO

Dear patient,

Thank you for giving me and my staff, at Midwest Neurosurgeons, LLC, the pleasure of caring for you. Please help us continue to improve ourselves by completing this evaluation. Your comments are very important to us and we thank you in advance.

Sincerely,

Sonjay Joseph Fonn, DO and Staff

1). Please tell us how our office rates on the following...

	Lower	Higher	Don't Know
Ease in getting an appointment?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Courtesy and professionalism of office staff?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Courtesy and professionalism of Dr. Fonn?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Dr. Fonn's accuracy in diagnosing a problem?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Bedside manner (caring)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Spending enough time with me?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Did our staff & Dr. Fonn keep you informed?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Did Dr. Fonn involve you in decisions?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Is Dr. Fonn easy to understand?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
What is your overall opinion of Dr. Fonn?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
How long was your average wait at the office?	_____ minutes		<input type="checkbox"/>

2). Are your signs & symptoms resolved after surgery? Yes No

3). What would you like to tell Dr. Fonn about your experience with us?

He was a very nice & very good
Dr. He did a good job with me

4). What would you want to tell others about Dr. Fonn?

He is a very good Dr.

5). Are you satisfied with your overall surgical experience? Yes No

May we place your comments on our website?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
Yes, May we use your Name?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No If no,
May we use your initials?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
May we post a picture of you beside your comments?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
(Optional) Patient Name: <u>Deanna Western</u>	Date: <u>2-14-13</u>	