

Richard J. Katz, M.D.
Morton Schneider, M.D.
Steven A. Albert, M.D.
Alison Bender Haimes, M.D.
Stephen D. Greenberg, M.D.
Douglas R. DeCorato, M.D.
Gavin L. Duke, M.D.



Barbara H. Braffman, M.D.
Clyde A. Hershan, M.D.
Paul S. Choi, M.D.
Sean K. Herman, M.D.
Robert L. Ludwig, M.D.
Gwen N. Harris, M.D.
Timothy Deyer, M.D.

519 & 523 East 72nd Street, New York, NY 10021 • 3 East 75th Street, At Fifth Avenue, New York, NY 10021
430 East 59th Street, Sutton Place, New York, NY 10022
Tel: 212-288-1575 • Fax: 212-288-7616
www.eastriverimaging.com

PATIENT QUESTIONNAIRE

Dear Patient:

Thank you for selecting East River Medical Imaging to have your diagnostic test performed. In our effort to improve the quality of our service and patient care, your opinion is important to us. We would appreciate your taking a few moments to fill out this questionnaire. *(Please check or circle all choices – more than one may apply)*

1. What test(s) did you have today?

MRI Ultrasound CT X-Ray PET Nuclear Scan Bone Density

2. How did you hear about our office?

Doctor Referral Friend/Relative Insurance Plan Other _____

3. When you called the office to schedule your appointment was the scheduling secretary

Friendly Unfriendly Professional Unprofessional

4. Were you able to schedule your appointment within a reasonable time?

Yes No

5. How did our reception personnel greet you when you arrived? Were they

Friendly Unfriendly Professional Unprofessional

6. When did your test begin?

On time Less than 10 minutes late 10 to 20 minutes late Over 20 minutes late

7. How did our technical staff treat you? Were they

Friendly Unfriendly Professional Unprofessional

8. How did you find your interactions with the business office personnel? Were they

Knowledgeable Uninformed Professional Unprofessional

9. How would you rate your overall visit to our office?

Excellent Very Good Good Fair Poor

10. Would you recommend our facility? (Why?)

11. Was a staff member especially helpful? (Who? Why?)

Please use this space to make any comments you wish.

Any suggestions you can make to help us improve our service or quality of care are greatly appreciated. Thank you for your help.

Your Name (optional) _____ Date of visit _____