



# Patient Survey

*Help us serve you better!*

Stephen H. Wolpo, D.D.S.

Thank you for visiting **Smile Sensations**. We hope you were impressed by our service and that you feel confident in recommending **Smile Sensations** to friends and relatives in the future. You can trust we will listen to your feedback and make changes when appropriate.

Please fill out the **Smile Sensations** survey below, and submit it in one of three ways:

- 1) Using the e-mail submit button (above). (or) 2) Fax to (203) 324-9633 (or) 3) Mail or deliver your completed survey to:  
**Smile Sensations** Patient Survey  
 60 Strawberry Hill Avenue, Ste L-2  
 Stamford, CT 06902

As our way of saying thank you for your feedback, we will enter you in the **Smile Sensations** monthly drawing for an opportunity to win such prizes as a Sonicare Toothbrush (\$120 value); In-Office Teeth Whitening (\$600 value) or a Nutritional Counseling Session (\$220 value)! Go to [www.SmileSensations.com/Practice/MonthlyDrawing/Tabid/87/Default.aspx](http://www.SmileSensations.com/Practice/MonthlyDrawing/Tabid/87/Default.aspx) for more information on the drawing and winners. Please call if you have questions about the survey (203) 323-9277.

**Purpose of Visit:**

<input type="radio"/> Exam/Cleaning	<input type="radio"/> Tooth Whitening	<input type="radio"/> Cosmetic Dentistry	<input type="radio"/> Invisalign	<input type="radio"/> Crowns/Bridges
<input type="radio"/> Nutritional Counseling	<input type="radio"/> Dental Implant	<input type="radio"/> Dentures/Partials	<input type="radio"/> Periodontal (gum)	<input type="radio"/> Pediatric

**Please Rate the Following:**

Your impression of the office (look and feel):

- Excellent     Good     Fair     Poor     No Answer

Quality of care provided by the office staff:

- Excellent     Good     Fair     Poor     No Answer    Wait Time:

Quality of care provided by dental specialist:    Name of Specialist

- Excellent     Good     Fair     Poor     No Answer

**Comments and Testimonial (optional):** Please include any comments below. We invite you to write a brief testimonial. You might include the reason for your visit, the ease of the scheduling process, your impressions of the office and staff, your satisfaction with the service you received, and how it helped fulfill the initial need that brought you to the practice.

May we use your testimonial in our marketing (includes but is not limited to website, printed material, commercials)?     Yes     No

To qualify for monthly drawing, please include your name and phone number below

Name <input type="text"/>	Phone <input type="text"/>
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