Patient Information Survey

Date: _____

First Name: _____ **Last Name**: _____

1) How did you first learn about New Jersey Headache Institute?

_____Referring Physician _____Friend
_____Newspaper _____Web Search
_____Yellow Pages _____Other

2) Did you call to make an appointment? Or, did you schedule your appointment on our website?

_____Telephone _____Website

3) Did we answer your questions to your satisfaction during your initial contact with us?

_____Yes _____No

If no, what question(s) did we not answer?

4) Why did you choose New Headache Institute?

_____I was referred _____Professionalism
_____Location _____Technologies offered
_____Pricing

5) Did you consider any other medical providers before coming to the New Jersey Headache Institute?

_____Yes _____No

If yes, please list providers considered:

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