Call Back Patient Information

Name: ___________________________________________ Date of visit: ______________________

Reason for visit: __________________________________________

Would you like a follow up call? YES NO

IF NO, please sign: __________________________________________

What is the best phone number to reach you at? ________________

What is the best time to call you? Morning 8am - 11am Afternoon noon- 4pm Evening 5pm -7pm

FOR OFFICE USE ONLY

How are you feeling today? ________________________________________

Did you get your medication filled? _____________________________

Did you make a follow up appointment with a PCP or Specialist? Do you have any questions or concerns about your visit?

How was your care at your visit? ________________________________

How was your overall experience at this facility? __________________

Was there a staff member who was especially helpful to you? Is there anything that could have been different?

Completed By: __________________________________________

Date: ____________________________ Time: ______________________