

Share your experience



Help us to share your experiences with others by circling the following questions and providing us with a description of the time you have spent visiting Leamington Spa Orthodontics.

	Not at all	Sometimes	Never thought about it	Most of the time	All of the time
Do you feel SAFE in the practice?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Do you feel that your care and treatment is EFFECTIVE ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Do you believe that the team CARE about you as an individual?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Do you feel that you are treated FAIRLY, EQUALLY and without discrimination?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Do you feel INVOLVED with your care and treatment?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Do you believe that we are appropriately RESPONSIVE to you when you have questions or concerns?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Do you believe that the practice is WELL-LED ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Your feedback

Your personal details

Name	Age
Town	

Thank you so much for your contribution – we want everyone to enjoy the journey to a new smile just as much as you have!

Your name will appear as 'First, Last Initial' on any materials we include it in. We respect your right to privacy and will not distribute any personal information (phone numbers, email, etc.) to any third party.

Consent & Release Terms and Conditions:

Through my signature below, I hereby authorise Leamington Spa Orthodontics to reproduce my testimonial, in full or in part, in its marketing materials and website. I understand my testimonial may be edited for clarity and/or conciseness. I am happy to have my photograph used and I am available for this to be taken on:

Signed	Date
	Time

The NHS friends and family test

We would like you to think about your recent experience of our service

	Extremely likely	Likely	Neither likely or unlikely	Unlikely	Extremely unlikely	Don't know
How likely are you to recommend our dental practice to friends and family?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Thinking about the response to this question, what is the main reason why you feel this way?

Are you? <input type="checkbox"/> Male <input type="checkbox"/> Female	What age are you? <input type="checkbox"/> 0-15 <input type="checkbox"/> 35-44 <input type="checkbox"/> 65-74 <input type="checkbox"/> 16-24 <input type="checkbox"/> 45-54 <input type="checkbox"/> 75-84 <input type="checkbox"/> 25-34 <input type="checkbox"/> 55-64 <input type="checkbox"/> 85+	Do you consider yourself to have a disability? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text" value="Details"/>
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We would like you to think about your recent experience of our service

White <input type="checkbox"/> British <input type="checkbox"/> Irish <input type="checkbox"/> Other White background	Asian or Asian British <input type="checkbox"/> Indian <input type="checkbox"/> Pakistani <input type="checkbox"/> Bangladeshi <input type="checkbox"/> Chinese <input type="checkbox"/> Other Asian background	Mixed <input type="checkbox"/> White and Black Caribbean <input type="checkbox"/> White and Black African <input type="checkbox"/> White and Asian <input type="checkbox"/> Other Mixed background	Black or Black British <input type="checkbox"/> Caribbean <input type="checkbox"/> African <input type="checkbox"/> Other Black background	Other <input type="checkbox"/> Anything else <input type="checkbox"/> I would rather not say
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Are you?
 The patient The parent or carer The patient and parent/carers

Thank you for completing the card and providing us with feedback to improve our services. If you DO NOT wish your comments to be shared then please tick here.