**Patient Satisfaction Treatment Completion Survey**

1. How would you assess your overall satisfaction with the treatment you have received? (1 – 5 scale poor to excellent)
2. How would you rate the overall quality of care you have received to date?

(1 – 5 scale poor to excellent)

1. Have your main dental concerns been addressed? Yes/no
2. Have your quality of life improved since you started dental treatment with us? Yes/no
3. How would you describe the care you received here according to your expectations?

Below expectations/met expectations/exceeded expectations

1. How would you assess your overall satisfaction with the schedule of your dental appointments? (1 – 5 scale poor to excellent)
2. How would you rate the way your dental provider(s) has treated your dental concerns to date?

(1 – 5 scale poor to excellent)

1. How would you rate the contributions of the supervising faculty to your dental care needs? (1 – 5 scale poor to excellent)
2. Would you say your understanding of the different ways to prevent cavities and gum disease has improved? (yes/no)
3. Have you changed the way or how often you brush your teeth since you started treatment with us? Yes/no
4. Have you changed the way or how often you floss your teeth since you started treatment with us? Yes/no
5. Have you changed the way you eat or drink since you started treatment with us? Yes/no

Do you have any additional comments you would like to share with us at this point?

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