



SURVEY QUESTIONNAIRE

Today's Date: _____ Program Location: _____ Your Name: _____

Doctor's Name: _____ Practice Name: _____

Doctor RDH Assistant Office Administrator Spouse Financial Coordinator Appt. Coordinator

No. of Years Doctor in Practice: _____ No. of Staff: _____ Solo Practice Group Practice

Specialty: _____ Home Phone: _____ Email Address: _____

Practice Address: _____

City/State/ZIP: _____ Office No.: _____ Fax No.: _____

What topic(s) or locations do you feel would be of interest for future lectures? _____

Additional comments: _____

Feel free to use my comments as testimonial. Signature: _____

How did you hear about this course? *(Please check all that apply)*

Brochure Ads Referral Another Program Other _____

- Please call me to discuss a ½ day or all day course for my dental office, professional organization, study club, or dental society.
- Please contact me regarding Banta Group Consulting, Inc.'s 12-month consulting services (in-house).
- Please contact me regarding Professional Retreats Seminars.
- Please contact me regarding Tele-consulting
- Please contact me regarding "in-office training" – for specific needs in your dental practice.

	Strongly Agree		Agree		Strongly Disagree	
Speaker addressed program objectives	5	4	3	2	1	
Speaker addressed doctor and staff concerns	5	4	3	2	1	
Material presented enthusiastically	5	4	3	2	1	
Speaker displayed comprehensive knowledge of program content	5	4	3	2	1	
Program was beneficial	5	4	3	2	1	
Program facilities met needs	5	4	3	2	1	

Thank you for taking the time to fill out this questionnaire.