Patient Testimonial Form

Patient Name _____

Would you like your name or initials used with your testimonial? _____

Can we use an excerpt of your testimonial? ___ Yes ___ No

Can we edit or revise your testimonial? ___ Yes ___ No

How long have you been a patient? _____

What did you have done today?

_____
_____
_____

Please tell us about your experience:

_____
_____
_____

How does your experience in our office differ from past experiences with other hearing aid offices?

_____
_____
_____

Would you recommend our office to your friends and relatives? _____

Feel free to use the back of this form for more writing space. Thank you, sincerely, for taking time to complete this form!