

A Free Service For PatientFYI Dentists!

The In-Office Patient Referral Program

*Before the In-Office Patient Referral Program... you could only **hope** that your satisfied Patients referred you to a **few** people a year... now you can **guarantee** that they refer you to **thousands** of people a day!*

What's Inside:

- **Program Details:** What is the In-Office Patient Referral Program?
- **Patient Experience Referral (By Service Category):** Forms that are specific to the category of Service that the Patient received. There are 10 Service Categories*.
- **Patient FAQ Hand-Out:** For you to give your Patients after they complete a Patient Experience Referral.

Use this program to quickly qualify as a recipient of the:



The same Patient can submit up to three (3) Patient Experience Referrals on the same Doctor within a 12-month period. So for those Patients that received multiple Services during the same visit (e.g. Cleaning & Teeth Whitening), they can complete separate forms for each Service Category and have both posted on PatientFYI.



What is the In-Office Patient Referral Program?

This exciting Program empowers you to maximize the positive opinions of your Patients by allowing them to quickly & easily complete a Patient Experience Referral (PER) before they leave your office. Then when submitted via fax to PatientFYI, we will manually post it online for thousands of other prospective-Patients to see.

Why should our Office utilize this Program?

There are many reasons you should consistently take advantage of this Program, including:

- The more Patient Experience Referrals you have posted on PatientFYI, not the scores themselves, dictate the order your Practice Profile will appear in the Search Results.
- This is the best way to ensure that your satisfied Patients' referral will be heard by thousands of prospective-Patients (*don't risk them getting distracted at home/the office and forgetting to submit a referral online*).
- One of PatientFYI's innovative features is that prospective-Patients can see the feedback from Patients that received the same Service that they need. With this Program you can ensure that there are positive Patient Referrals within each Service Category.
- **You can use/identify your positive results in your other marketing campaigns!**
- You can quickly qualify for the PatientFYI Award of Excellence!

How do we utilize this Program?

- Step 1:** Make multiple copies of the enclosed Patient Experience Referrals(s), & Patient FAQs Hand-Out and keep them on-hand.
- Step 2:** As your Patients are preparing to leave your office, have them complete the version of the Patient Experience Referral for the Service that they received during their visit (there are 10 categories of Services) – and give them a copy of the **Patient FAQ Hand-Out** (last page of document) for their reference.
- Step 3:** Fax them to (877) 386-7394.
- Step 4:** PatientFYI Representatives will manually enter your Patient Experience Referrals within 5 – 7 business days.

PATIENT EXPERIENCE REFERRAL (Exam & Cleaning)

Doctor's Last Name: _____ Phone Number: _____

Practice Address City: _____ ST _____ Zip _____

Please circle the applicable score, with 10 being the "Best" possible.

1. Would you recommend this Doctor to your family and friends?

1 2 3 4 5 6 7 8 9 10

2. Would you recommend the individual who performed your cleaning (this could be the HYGIENIST or DOCTOR) to your family and friends?

1 2 3 4 5 6 7 8 9 10

3. How would you rate the Front Office Staff's overall communication & service?

1 2 3 4 5 6 7 8 9 10

4. How well were oral hygiene homecare instructions explained?

1 2 3 4 5 6 7 8 9 10

5. Did you fully understand the cost of your Treatment before it began?

1 2 3 4 5 6 7 8 9 10

6. How would you rate the overall appearance and quality of the Office?

1 2 3 4 5 6 7 8 9 10

7. What would you like other patients to know about your experience at this Office?

Patient Information

Name (optional): _____

Email Address (required): _____

Gender: M or F Age: _____ New Patient in this Office: Yes or No

Would you like your Patient Experience Referral to be kept Anonymous? Yes or No

Your Name & Email Address are being asked for validation purposes only and will not be shared with anyone else. Please see PatientFYI.com for details.

**Upon completion, please fax to:
877-386-7394**

PATIENT EXPERIENCE REFERRAL – Teeth Whitening

Doctor's Last Name: _____ Phone Number: _____

Practice Address City: _____ ST _____ Zip _____

Please circle the applicable score, with 10 being the "Best" possible.

- 1. Would you recommend this Doctor to your family and friends?
1 2 3 4 5 6 7 8 9 10
- 2. How would you rate the Front Office Staff's overall communication & service?
1 2 3 4 5 6 7 8 9 10
- 3. Did you understand the instructions on how to minimize tooth sensitivity after the whitening?
1 2 3 4 5 6 7 8 9 10
- 4. Did you fully understand the cost of your Treatment before it was performed?
1 2 3 4 5 6 7 8 9 10
- 5. How would you rate the overall appearance and quality of the Office?
1 2 3 4 5 6 7 8 9 10
- 6. What would you like other patients to know about your experience at this Office?

Patient Information

Name (optional): _____

Email Address (required): _____

Gender: M or F Age: _____ New Patient in this Office: Yes or No

Would you like your Patient Experience Referral to be kept Anonymous? Yes or No

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PATIENT EXPERIENCE REFERRAL – Crown/Bridge

Doctor's Last Name: _____ Phone Number: _____

Practice Address City: _____ ST _____ Zip _____

Please circle the applicable score, with 10 being the "Best" possible.

- 1. Would you recommend this Doctor to your family and friends?
1 2 3 4 5 6 7 8 9 10
- 2. How would you rate the Front Office Staff's overall communication & service?
1 2 3 4 5 6 7 8 9 10
- 3. How comfortable is the fit of your new Crown/Bridge?
1 2 3 4 5 6 7 8 9 10
- 4. Did you fully understand the cost of your Treatment before it was performed?
1 2 3 4 5 6 7 8 9 10
- 5. How would you rate the overall appearance and quality of the Office?
1 2 3 4 5 6 7 8 9 10
- 6. What would you like other patients to know about your experience at this Office?

Patient Information

Name (optional): _____

Email Address (required): _____

Gender: M or F Age: _____ New Patient in this Office: Yes or No

Would you like your Patient Experience Referral to be kept Anonymous? Yes or No

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PATIENT EXPERIENCE REFERRAL - Filling

Doctor's Last Name: _____ Phone Number: _____

Practice Address City: _____ ST _____ Zip _____

Please circle the applicable score, with 10 being the "Best" possible.

1. Would you recommend this Doctor to your family and friends?

1 2 3 4 5 6 7 8 9 10

2. How would you rate the Front Office Staff's overall communication & service?

1 2 3 4 5 6 7 8 9 10

3. How smooth was the Filling after it was completed?

1 2 3 4 5 6 7 8 9 10

4. Did you fully understand the cost of your Treatment before it was performed?

1 2 3 4 5 6 7 8 9 10

5. How would you rate the overall appearance and quality of the Office?

1 2 3 4 5 6 7 8 9 10

6. What would you like other patients to know about your experience at this Office?

Patient Information

Name (optional): _____

Email Address (required): _____

Gender: M or F Age: _____ New Patient in this Office: Yes or No

Would you like your Patient Experience Referral to be kept Anonymous? Yes or No

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PATIENT EXPERIENCE REFERRAL - Implant

Doctor's Last Name: _____ Phone Number: _____

Practice Address City: _____ ST _____ Zip _____

Please circle the applicable score, with 10 being the "Best" possible.

1. Would you recommend this Doctor to your family and friends?

1 2 3 4 5 6 7 8 9 10

2. How would you rate the Front Office Staff's overall communication & service?

1 2 3 4 5 6 7 8 9 10

3. How would you rate the pain of the surgical placement of the Implant?

1 2 3 4 5 6 7 8 9 10

4. Did you fully understand the cost of your Treatment before it was performed?

1 2 3 4 5 6 7 8 9 10

5. How would you rate the overall appearance and quality of the Office?

1 2 3 4 5 6 7 8 9 10

6. What would you like other patients to know about your experience at this Office?

Patient Information

Name (optional): _____

Email Address (required): _____

Gender: M or F Age: _____ New Patient in this Office: Yes or No

Would you like your Patient Experience Referral to be kept Anonymous? Yes or No

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PATIENT EXPERIENCE REFERRAL – Dentures & Partials

Doctor's Last Name: _____ Phone Number: _____

Practice Address City: _____ ST _____ Zip _____

Please circle the applicable score, with 10 being the "Best" possible.

1. Would you recommend this Doctor to your family and friends?

1 2 3 4 5 6 7 8 9 10

2. How would you rate the Front Office Staff's overall communication & service?

1 2 3 4 5 6 7 8 9 10

3. How much better can you chew and talk with your new Denture/Partial than before?

1 2 3 4 5 6 7 8 9 10

4. Did you fully understand the cost of your Treatment before it was performed?

1 2 3 4 5 6 7 8 9 10

5. How would you rate the overall appearance and quality of the Office?

1 2 3 4 5 6 7 8 9 10

6. What would you like other patients to know about your experience at this Office?

Patient Information

Name (optional): _____

Email Address (required): _____

Gender: M or F

Age: _____

New Patient in this Office: Yes or No

Would you like your Patient Experience Referral to be kept Anonymous? Yes or No

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PATIENT EXPERIENCE REFERRAL – Oral Surgery & Extractions

Doctor's Last Name: _____ Phone Number: _____

Practice Address City: _____ ST _____ Zip _____

Please circle the applicable score, with 10 being the "Best" possible.

1. Would you recommend this Doctor to your family and friends?

1 2 3 4 5 6 7 8 9 10

2. How would you rate the Front Office Staff's overall communication & service?

1 2 3 4 5 6 7 8 9 10

3. How would you rate the level of pain you experienced during your Treatment?

1 2 3 4 5 6 7 8 9 10

4. Did you fully understand the cost of your Treatment before it was performed?

1 2 3 4 5 6 7 8 9 10

5. How would you rate the overall appearance and quality of the Office?

1 2 3 4 5 6 7 8 9 10

6. What would you like other patients to know about your experience at this Office?

Patient Information

Name (optional): _____

Email Address (required): _____

Gender: M or F Age: _____ New Patient in this Office: Yes or No

Would you like your Patient Experience Referral to be kept Anonymous? Yes or No

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PATIENT EXPERIENCE REFERRAL – Periodontal

Doctor's Last Name: _____ Phone Number: _____

Practice Address City: _____ ST _____ Zip _____

Please circle the applicable score, with 10 being the "Best" possible.

1. Would you recommend this Doctor to your family and friends?

1 2 3 4 5 6 7 8 9 10

2. How would you rate the Front Office Staff's overall communication & service?

1 2 3 4 5 6 7 8 9 10

3. How well did the Doctor explain the X-Rays to help you understand bone loss around your teeth?

1 2 3 4 5 6 7 8 9 10

4. Did you fully understand the cost of your Treatment before it was performed?

1 2 3 4 5 6 7 8 9 10

5. How would you rate the overall appearance and quality of the Office?

1 2 3 4 5 6 7 8 9 10

6. What would you like other patients to know about your experience at this Office?

Patient Information

Name (optional): _____

Email Address (required): _____

Gender: M or F Age: _____ New Patient in this Office: Yes or No

Would you like your Patient Experience Referral to be kept Anonymous? Yes or No

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PATIENT EXPERIENCE REFERRAL – Root Canal

Doctor's Last Name: _____ Phone Number: _____
Practice Address City: _____ ST _____ Zip _____

Please circle the applicable score, with 10 being the "Best" possible.

1. Would you recommend this Doctor to your family and friends?
1 2 3 4 5 6 7 8 9 10
2. How would you rate the Front Office Staff's overall communication & service?
1 2 3 4 5 6 7 8 9 10
3. How well did the Doctor explain what you would experience during your Treatment?
1 2 3 4 5 6 7 8 9 10
4. Did you fully understand the cost of your Treatment before it was performed?
1 2 3 4 5 6 7 8 9 10
5. How would you rate the overall appearance and quality of the Office?
1 2 3 4 5 6 7 8 9 10
6. What would you like other patients to know about your experience at this Office?

Patient Information

Name (optional): _____

Email Address (required): _____

Gender: M or F Age: _____ New Patient in this Office: Yes or No

Would you like your Patient Experience Referral to be kept Anonymous? Yes or No

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PATIENT EXPERIENCE REFERRAL - Orthodontia

Doctor's Last Name: _____ Phone Number: _____

Practice Address City: _____ ST _____ Zip _____

Please circle the applicable score, with 10 being the "Best" possible.

1. Would you recommend this Orthodontist to your family and friends?

1 2 3 4 5 6 7 8 9 10

2. How would you rate the Front Office Staff's overall communication & service?

1 2 3 4 5 6 7 8 9 10

3. How well was the importance of maintaining oral hygiene at home emphasized when you began your orthodontia treatment?

1 2 3 4 5 6 7 8 9 10

4. Did you fully understand the cost of your Orthodontia before you began treatment?

1 2 3 4 5 6 7 8 9 10

5. How would you rate the overall appearance and quality of the Office?

1 2 3 4 5 6 7 8 9 10

6. What would you like other patients to know about your experience at this Office?

Patient Information

Name (optional): _____

Email Address (required): _____

Gender: M or F Age: _____ New Patient in this Office: Yes or No

Would you like your Patient Experience Referral to be kept Anonymous? Yes or No

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Patient FAQs Handout

Is my Email Address required?

In order for a Patient Experience Referral to be posted on PatientFYI, the submitter must provide a valid email address. *Your email address will NOT be shared with any third parties.*

What is PatientFYI?

PatientFYI (www.PatientFYI.com) is an innovative & free resource that helps Patients find the best Doctors by providing unprecedented information on your Doctor's strengths, services & satisfied-Patients.

What happens to the Patient Experience Referral Form once I complete it?

Your Doctor's office will send it to PatientFYI and our team manually enters it into our system for WebMD's 54 million monthly Patients (and many others) to utilize when looking for a Doctor.

Can I submit my Patient Experience Referral online?

Absolutely – just go to www.PatientFYI.com.

What if I want to modify or add content to my Patient Experience Referral?

Simply log-on to your account within 72 hours of receiving your confirmation email from PatientFYI – you can then add content and/or answer a few additional questions regarding your experience at this office.

We will set-up a Username & temporary Password that you can change at your convenience. Your Username will be your Email Address (as provided on the Form) and your temporary Password will be "patientfyi" (case sensitive).

What is the PatientFYI Award of Excellence?

This is a special award driven by Patients like you, having completed the Patient Experience Referral, that recognizes those Doctors that have excelled in their delivery of Treatment Results, Patient Communications & Office Capabilities.

www.PatientFYI.com