Personal Dental Needs Survey

Name: _____ Date:_____

Please rate on a scale of 1 - 5 the importance of each of the following regarding your dental care. (The most important would be #1.)

_____ Preventive Dental Health care
_____ Excellence and Quality of service
_____ Other _____
_____ Freedom from pain
_____ Cost and Affordability

Please rate, as above, what a dentist has to do to gain your confidence.

_____ Show me what he/she is doing or needs to do so I can clearly understand what is happening.
_____ Listen to my concerns and explain thoroughly the procedures to be performed.
_____ Make sure I feel comfortable and informed at all times.

Please circle the level of fear you have about your dental visits. (10 being the greatest fear.)

1 2 3 4 5 6 7 8 9 10

I would like to know about these options available to me for maximizing my comfort and my experience during my visit. (Check all that apply.)

_____ Music and earphones (please list the type of music) _____.
_____ Nitrous Oxide
_____ Sedative Medication
_____ Patient Education Materials

Are you concerned about the following? (Yes or No):

_____ Existing discomfort?
_____ Replacing old silver fillings?
_____ Recurring or untreated gum disease?
_____ Mouth odor?
_____ Whitening your teeth?
_____ Appearance of my smile?
_____ Prevention of decay?
_____ Other _____

PLEASE CIRCLE ONE:

When discussing my treatment plan, I prefer:

THE BIG PICTURE DETAIL BY DETAIL

When evaluating my smile, it's most important:

WHAT I SEE WHAT OTHERS SEE