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 medications
___ 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