daxon
DENTISTRY

Name: _____ Date: _____

Please rate on a scale of 1-5 the importance of each of the following regarding your dental care, with 1 being very important, and 5 being not important at all.

_____ Preventative Dental Health Care

_____ Excellence and Quality of Service

_____ Freedom from Pain

_____ Cost and Affordability

_____ Other _____

_____

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 for 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?

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