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, on a scale from 1-3, what a dentist has to do to gain your confidence. (The most important would be #1)

___ Show me what he 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)

___ Nitrous Oxide
___ Sedative Medications (Valium)
___ Patient Education Materials

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

___ Existing discomfort?
___ Replacing old mercury-silver amalgam fillings?
___ Recurring or untreated gum disease?
___ Mouth odor?
___ Whitening your teeth?
___ Appearance of your smile? (Cosmetics)
___ Prevention of decay?
___ Other _____

Given my past experience, I expect to keep my natural teeth until I am _____ years old.

When discussing my treatment plan, I prefer. . . (Circle One)

THE BIG PICTURE DETAIL BY DETAIL

Is there anything else that you think we should know about your care and treatment in our office?

_____
_____
_____
_____

Thank you for taking the time to assist us in getting to know you.
We look forward to a long and happy professional relationship!