PERSONAL DENTAL NEEDS SURVEY

Name: ____ Date: ____________________

Please rank the order of importance of each of the following regarding our dental care (please rank from 1 - 5, #1 being most important):

_____ Preventative Health Care
_____ Excellence & Quality of Service
_____ Other ____________________
_____ Freedom From Pain
_____ Cost & Affordability

Please rank in order of importance, "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 thoroughly explain the procedures to be performed.
_____ Make sure I feel comfortable and informed at all times.

On a scale of 1 -10, what is the level of fear/anxiety you have about your dental visits.

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 (please check all that apply).

_____ Music & Earphones (Please list the type of music: ________________________________)
_____ Nitrous Oxide
_____ Sedative Medication
_____ Patient Education Materials

Are you concerned about the following? ("Y"es or "N"o)

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

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

Do you have dental insurance? YES _____ NO _____

If you do not have dental insurance, would you still have your dental care completed?

YES _____ NO _____