PERSONAL DENTAL NEEDS SURVEY

Please rate on a scale of 1-6 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
___Time

Please rate, (as above but 1 to 3), what a dentist must 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? (Check all that apply):

___Existing discomfort?
___Replacing old silver fillings?
___Recurring or untreated gum disease?
___Mouth odor?
___Whitening your teeth?
___Appearance of my smile?
___ Prevention of decay?
___Other_____________

What is your primary dental concern?

PLEASE CIRCLE ONE:

When discussing my treatment plan, I prefer: THE BIG PICTURE or DETAIL BY DETAIL

When evaluating my smile, it's most important: WHAT I SEE or WHAT OTHERS SEE