General, Cosmetic & Implant Dentistry

PERSONAL DENTAL NEEDS SURVEY

I consider my dental health to be:
____Excellent ____Good ____Fair ____Poor

On a scale of 1 to 10, what priority do you give your teeth? (10 being the highest):
(   )

Please number each concern in order of importance regarding your dental care (5 being highest in priority):
___Preventive Dental Health care ___Freedom from pain ___Other (Please Specify) _________________
___Excellence and quality of service ___Cost and affordability

Please rate what a dentist has to do to gain your confidence (1 - most important, 2 – important, 3 – least important):
___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 indicate the level of fear you have about your dental visits (10 being the greatest fear):
(   )

I would like to know about these options available during my visit to enhance comfort (Check all that apply):
___Patient education materials ___Music and earphones ___TV Viewing

I am concerned about the following (Check all that apply):
___Existing discomfort? ___Whitening your teeth? ___Replacing old silver fillings?
___Prevention of decay? ___Short/worn teeth? ___Appearance?
___Mouth odor? ___Jaw clicking/popping? ___Recurring or untreated gum disease?

I'm more interested in (please check only one):
___Interested in straightening your teeth ___Interested in whitening your teeth.

If you could change your teeth/smile, what would you change?
____

When discussing my treatment plan, I prefer (please check only one):
___The Big Picture ___Detail By Detail

When evaluating my smile, it's most important (please check only one):
___What I See ___What Others See

Name: ____________________________________ Date: _____/_____/_____