

**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, 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 to me for maximizing my comfort and my experience during my visit. (Check all that apply.)**

- \_\_\_ Music and earphones
- \_\_\_ 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?
- \_\_\_ Other \_\_\_\_\_

**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