



PERSONAL DENTAL NEEDS SURVEY

Patient Name:
Last First MI Preferred Name

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)

Preventative Dental Health Care

1 2 3 4 5

Excellence and Quality of Service

1 2 3 4 5

Freedom from Pain

1 2 3 4 5

Cost and Affordability

1 2 3 4 5

Other

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.

1 2 3 4 5

Listen to my concerns and explain thoroughly the procedures to be performed.

1 2 3 4 5

Make sure I feel comfortable and informed at all times.

1 2 3 4 5

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Please indicate, 1-10, 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 the options available to me for maximizing my comfort and my experience during my visit.
(Check all that apply)

- Music and earphone Pillow Blanket
 Anti-anxiety medications Patient Education Materials

Are you concerned about the following? (Check all that apply)

- Sore muscles/headaches Existing discomfort
 Replacing old silver fillings Recurring or untreated gum disease
 Mouth odor Worn teeth
 Uneven bite Whitening your teeth
 Appearance of my smile Prevention of decay
 Other

Other

Please Choose One. When discussing my treatment plan, I prefer:

- The Big Picture Detail by Detail

Response Date: