Erskine Family Dentistry
erskinefamilydentistry.com business@erskinefamilydentistry.com
734 E. Ireland Rd. • South Bend, IN 46614 (574)299-9300

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

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:

____/____/________