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)

_____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