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Personal Dental Preferences

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, do not use the same number twice.)

Preventative Dental Health Care

Freedom from pain

Excellence and Quality of service

Cost and affordability

Other Please Specify

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

☐ Patient education materials

Are you concerned about the following? (Yes or No):

Existing discomfort?

☐ Yes ☐ No

Replacing old silver fillings?

☐ Yes ☐ No

Recurring or untreated gum disease?

☐ Yes ☐ No

Mouth Odor?

☐ Yes ☐ No

Whitening your teeth?

☐ Yes ☐ No

Appearance of my smile?

☐ Yes ☐ No

Prevention of decay?

☐ Yes ☐ No

Other

☐ Yes ☐ No

When discussing my treatment plan, I prefer (please check choice):

☐ The Big Picture

☐ Detail by detail

When evaluating my smile. It is most important:(please check choice):

☐ What I see

☐ What others see