Prestige Dentistry

PERSONAL DENTAL NEEDS SURVEY

Name: ___________________________ Date: __________________

Please rate in order of importance, your primary concerns regarding your dental care. (The most important would be #1)

___Preventative Dental Health care ___Freedom from pain
___Excellence and Quality of service ___Cost and affordability
___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.
___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

Please circle how important your dental health is to you. (10 being the highest importance.)

____ 1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health? (10 being the highest rating.)

____ 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 ___Sedative medications
___Nitrous Oxide ___Patient education materials

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

___Existing discomfort? ___Whitening your teeth?
___Replacing old silver fillings? ___Prevention of decay?
___Recurring or untreated gum disease? ___Short/worn teeth, cosmetics?
___Mouth odor? ___Jaw clicking/popping?
___Having smile makeover? ___Replacing old crowns that don’t match?
___Grinding or clenching teeth? ___Sensitivity (hot, cold, sweet)?

Why did you leave your previous dentist?__________________________________________

What is the most important thing to you about your future smile and dental health?________

________________________________________________________________________________

What is the most important thing to you about your dental visit today?____________________

________________________________________________________________________________

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