Patient Questionnaire

One of the goals of our office is to always understand and meet the needs of our patients. We are committed to you having your visits in our office be exceptional experiences. The comfort and quality of care you receive here are among our highest priorities

1. Please rate (1 best↔4 least) your primary concerns regarding your dental care.

   _____Preventive Dental Health Care _____Excellence & Quality of Service

   _____Cost & Affordability _____Other_____

2. Please rate what a dentist must do to gain your confidence.

   _____Show me what he is doing or needs to do, so I can clearly understand the necessity

   _____Listen to my concerns and explain necessary procedures thoroughly

   _____Take steps to make sure I feel comfortable and informed at all times

3. Please circle the level of fear you have about your dental visit (1 none ↔ 10 greatest fear)

   1 2 3 4 5 6 7 8 9 10

4. I would like to know about the following options available for maximizing my comfort during treatment.

   _____Music & Earphones _____Sedative Medication

   _____Nitrous Oxide _____Video Choice

5. Do you have or are you concerned about…

   _____Any missing teeth _____Problems with bad breath

   _____Untreated dental disease _____Do you have concerns about your smile

   _____Bleeding or sensitive gums _____The color of your teeth

6. Ideally, I would like to keep my natural teeth _____Yes _____No

7. How often do you…

   _____Have you teeth professionally cleaned _____Floss your teeth

   _____Have routine dental examinations _____Have an oral cancer screening

   _____Brush your teeth _____Dental Radiographs

8. How often do you think you should…

   _____Have you teeth professionally cleaned _____Floss your teeth

   _____Have routine dental examinations _____Have an oral cancer screening

   _____Brush your teeth _____Dental Radiographs

9. Is there anything else that you think we should know about your care and treatment in our office?

   _____

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