Patient name_____

Date_____

Our goal is to make your experience in our office exactly how you want it to be. Please take a few moments and complete this profile so we can make you as comfortable as possible.

1. Please rate, in order of value, what is most important to you in your dental care: (The most important will be #1.)

   ____ Preventive Care

   ____Only what is necessary at the time: Cost is important

   ____ Comprehensive, Quality Care

   ____ Other _____

2. Please rate, as in #1, what is most important to you in your relationship with at dentist.

   ____ Show me what he/she is doing or planning to do so I can clearly see what is happening.

   ____ Listen to my concerns and explain what needs to be done so I can clearly hear and understand my needed treatment.

   ____ Make sure I feel comfortable and informed at all times.

3. Please circle the level of fear you have regarding dental treatment. (10 being the most fearful, 1 being the least amount of fear.)

   1 2 3 4 5 6 7 8 9 10

4. I would like to know more about these options to maximize my comfort during my visits.

____ Music and earphones

____ Nitrous Oxide (laughing gas)

____ Sedative Medication

____ Extensive Sedation

5. Are you concerned about: (please circle yes or no)

Yes No Replacing missing teeth.

Yes No Eliminating any disease present in my mouth.

Yes No Gum Disease.

Yes No Bad Breath.

Yes No The appearance of my smile.

6. Is keeping you natural teeth important to you? Yes No

7. I would like to keep my natural teeth until _____.

8. When we review your treatment plan with you, would you like to know (please check one:)

____ The big picture of what needs to be done.

____ All the treatment details along the way.

Notes: