Personal Dental Needs Survey

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.)

____ 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 she is doing or needs to do so as the patient 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

Are you concerned about the following? (yes or no):

____ Existing discomfort?
____ Whitening your teeth?
____ Replacing old silver fillings?
____ Appearance of my smile?
____ Recurring or untreated gum disease?
____ Prevention of decay?
____ Mouth odor?
____ Other__________________________

When evaluating my smile, it's most important:
What I See What Others See

I am looking for comprehensive dental care that will address all of my dental needs. Yes or No

I am looking to be seen only for dental cleanings? Yes or No

Do you have dental insurance? Yes or No

If you did not have dental insurance, would you still have your dental care completed? Yes or No

Please Circle one:
When discussing my treatment plan, I prefer:
The Big Picture Detail by Detail

How did you find Serene Oaks Dental?

__Referral
__Magazine Ad
__Phone Book
__Facebook
__Website Search
__Movie Theater
__Insurance Website
__Other