DENTAL NEEDS SURVEY

Date of your last dental appointment?_____
How often do you brush your teeth? _____
How often do you floss your teeth? _____
What type of oral hygiene tools do you use? _____
Do your gums bleed at any time?..... ☐YES ☐NO
Do you have aching or sensitive teeth?..... ☐YES ☐NO
Have you ever had an injury to your face or jaw?..... ☐YES ☐NO
Do you presently have or have you had *pain or discomfort* in the mouth, face, jaws or jaw joints (TMJs)?.. ☐YES ☐NO
Have you had trouble associated with any previous dental treatment?..... ☐YES ☐NO

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):

_____ Preventive Dental Health Care

_____ Freedom From Pain

_____ Excellence & Quality of Service

_____ Cost & 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 check 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 mercury silver fillings?

_____ Appearance of my smile?

_____ Recurring or untreated gum disease?

_____ Prevention of decay?

_____ Mouth odor?

_____ Other: _____

Patient's Name: _____