Pi Dental Center
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Name:_____

Chart Number: _____

Date: _____

Patient Personal Dental Needs Questionnaire

Please rate the following in the order of importance in regard to your dental care -- (rate 1-5 with #1 being the most important):

___ Preventive Dental Treatment ___ Quality of Service ___ Other _____

___ Pain Management ___ Cost and Affordability

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

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.)

___ Nitrous Oxide ___ Sedative Medications

___ Music and Earphones (please list the type of music) _____

___ Patient Education Materials

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

___ Pain ___ Teeth Whitening

___ Replacing Old Silver Fillings ___ Smile Appearance

___ Gum Disease ___ Prevention of Decay

___ Mouth Odor ___ Missing Teeth

___ Chipped Teeth ___ Other _____

Have you ever experienced any of the following in other dental offices? (Yes or No):

___ Dentist did not listen to or address my concerns.

___ Dentist did not evaluate my condition and thoroughly explain procedures to be performed.

___ Dentist did not keep me comfortable and informed during treatment.

___ Other (Please Explain) _____

When discussing my treatment plan, I prefer:

____ The Big Picture ____ Every Detail ____ Just address the problem

When evaluating my smile, it is most important:

____ What I see ____ What others see ____ Esthetics doesn't matter to me