Patient Smile Assessment

Dental Need Survey

	YES	NO
Do you like to smile wide enough to show your teeth?	( )	( )
Are you happy with the way your teeth look?	( )	( )
Do you like the look of your crowns and fillings?	( )	( )
Are your teeth to long? Too short?	( )	( )
Do you brush your teeth very hard?	( )	( )
Are you missing teeth?	( )	( )
Are you familiar with the benefits of implants?	( )	( )
Are you interested in aesthetics (cosmetic dentistry)?	( )	( )

If you could change one thing about your smile what would it be?

_____

_____.

Please rate each item on a scale (1-5) on the importance of each of the following topics regarding your dental care. (One being most important)

__Preventative Dental Health Care

__ Freedom from Pain

__ Excellence and Quality of Service

__ Cost and Affordability

Please circle the level of fear you have about 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)

__Music and Earphones

__ Patient Education Materials

__ Nitrous Oxide

__Sedative Medications

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

__ Existing discomfort in teeth or gums

__Whitening your smile

__Replacing old silver fillings

__ Improving the appearance of your smile

__Recurring or untreated gum disease

__ Prevention of decay

__ Mouth odor

__ Other_____

Please Circle One: When discussing my treatment plan, I prefer:

THE BIG PICTURE DETAIL BY DETAIL

When evaluating my smile, it's most important:

WHAT I SEE WHAT OTHERS SEE