Patient Name: _____ Date: _____

Parent/Guardian's Name: _____ Email: _____

Our goal is to your experience in our office exactly how <u>you</u> 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 a 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. Are you concerned about: (please circle yes or no)
   Yes No Replacing missing teeth
   Yes No Eliminating any disease present in your mouth.
   Yes No Gum disease
   Yes No Bad breath
   Yes No The appearance of your smile

5. Is keeping your natural teeth important to you? Yes No

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

5. 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: