DENTAL HEALTH QUESTIONNAIRE

919-859-1000 | email to: team@dentistrybydesignofcary.com

DENTISTRY by DESIGN of Cary
Evidence-Based Medicine

Printed Patient Name:_____ **Date of Birth:** _____

Please check one box in each section:

- ☐ My mouth is very comfortable.
- ☐ My mouth is moderately comfortable.
- ☐ My mouth is uncomfortable.

- ☐ I think the appearance of my smile is excellent.
- ☐ I am satisfied with the appearance of my smile.
- ☐ I would like to change my smile.
- ☐ I am unconcerned about the appearance of my smile.

- ☐ I will do whatever I must to keep my teeth.
- ☐ I want to keep my teeth but only within a certain budget of time and money.
- ☐ I am indifferent about keeping my teeth.

- ☐ I have always done what was recommended to me.
- ☐ I have not always done what was recommended to me.
- ☐ I have not previously had optimal health dentistry recommended to me.

- ☐ I put dental care high on my list for myself.
- ☐ I put dental care low on my list for myself.
- ☐ I have never considered where I put dental care on my list for myself.

- ☐ I think my present state of dental health is excellent.
- ☐ I think my present state of dental health is good.
- ☐ I think my present state of dental health is poor.

- ☐ I think there is need for improvement in my dental health.
- ☐ I do not think there is need for improvement in my dental health.
- ☐ I have not previously had any recommendation to make improvement in my dental health.

For the question below, if you select *MORE THAN ONE OF THE FOLLOWING*, please number them in order of significance, with #1 being that which is most significant for you at this time.

Obstacles I see to having excellent dental care for myself…

_____ I see no obstacle
_____ Time away from work or other obligations
_____ Fear of pain, surgery, or injections
_____ Fear because of past dental experiences
_____ The cost of treatment

My preference would be:

- ☐ To be told in detail about what is going on in my mouth.
- ☐ To be told in general terms what is going on in my mouth.
- ☐ To be shown pictures so that I can understand and see what is going on in my mouth.
- ☐ To view videos or websites to get more information about my dental problems and solutions.
- ☐ To talk with a team member about my dental problems and solutions.
- ☐ Other_____

Printed Name of the PERSON COMPLETING FORM: _____

If other than patient, indicate relationship to patient: _____

Date: _____ Signature:_____

Date: _____ Dental Provider'sSignature:_____