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WE'RE CONCERNED ABOUT YOU

We understand that you are unique and have unique concerns. So that we can provide you with the best possible care, please check off the statements that apply to you.

Name: _____	(Yes)	(No)
1. I am nervous being in a dental chair.	_____	_____
2. I have had a bad experience in a dental office.	_____	_____
3. I sometimes get dizzy lying back in a dental chair.	_____	_____
4. I have had difficulty with gagging or suctioning.	_____	_____
5. I would like to take breaks during long appointments.	_____	_____
6. My teeth or gums are very sensitive.	_____	_____
7. I don't like dental noises such as drilling or suctioning.	_____	_____
8. I have concerns about appointment scheduling.	_____	_____
9. I would like extra care to relieve pain.	_____	_____
10. I like having brochures or some things in writing.	_____	_____
11. I will need to relay what you tell me to my spouse or another.	_____	_____
12. I don't like shots (or have had a bad experience with them).	_____	_____
13. I have concerns about the appearance of my teeth or smile.	_____	_____
14. I have concerns about eating, chewing, or bad breath.	_____	_____
15. I have concerns about insurance or finances.	_____	_____
16. I have another question or concern. (Please write it below.)	_____	_____

Thank you for giving us your thoughts. Dr. Elliot & Staff