

Patient Name: _____ Date: _____

Parent/Guardian's Name: _____ Email: _____

Our goal is to make you and your child's experience in our office exactly how you 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 child's 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 child's 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 child's needed treatment.
 Make sure I and my child feel comfortable and informed at all times.

3. Please circle the level of fear your child has 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. Please circle the level of fear you have regarding dental treatment for yourself.
(10 being the most fearful, 1 being the least amount of fear.)
1 2 3 4 5 6 7 8 9 10

5. I would like to know more about these options to maximize my child's comfort during their visits.
 Nitrous Oxide (laughing gas)
 Sedative Medication

6. Are you concerned about: (please circle yes or no)
Yes No Replacing missing teeth
Yes No Eliminating any cavities
Yes No Gum disease
Yes No Bad breath
Yes No The appearance of your child's smile/Braces
Yes No Your child's brushing effectiveness

6. Is maintaining your child's natural teeth important to you? Yes No

7. When we review your child's 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: