Dental Concerns Assessment

Patient's Name_____ Date_____

Please rank your concerns or anxiety over the dental procedures listed below.

Please fill in any additional concerns.

	Level of Concern				
	None	Low	Med.	High	Explain
1. Anesthetic ("Novocaine") ……					
2. Radiographs ("X-Rays")…….					
3. Jaw getting tired…….....					
4. Gag reflex……					
5. Fear of being injured……					
6. Not being in control or able to stop the dentist……..					
7. The amount of treatment needed……..					
8. Sounds and/or smells in the dental office…….					
9. Not feeling free to ask questions or to be listened to……					
10. Receiving too little information…….					
11. Too many short appointments or too long of appointments…					
12. Please rate your smile					
(Dislike it) 1 2 3 4 5 6 7 8 9 10 (Love it)					
Do you require premedication or Nitrous Oxide with your dental care?					
Comments:					