

## Handle Me with Care

Please complete this survey to help us better understand your individual needs.

Check each box that applies to you:

- I gag easily.
- I feel out of control when I am lying down in the dental chair.
- I have not been to the dentist for a long time and I feel uncomfortable about what you will say or think about my teeth and my dental hygiene.
- I know I have bad habits that are causing harm to my dental health. I am afraid I might not be able to break them.
- Pain relief is a top priority to me.
- I don't like shots, or I've had a bad reaction to shots.
- Please tell me what I need to know about my mouth so I can make an informed decision.
- My teeth are very sensitive.
- I don't like the sound of the drill.
- I don't like the picking and scraping noise.
- I don't like the cotton in my mouth.
- I don't like the dental office smells.
- Please respect my time. I don't want to be left in the reception area.
- I have difficulty listening and remembering what I hear while sitting in the dental chair.
- I have health problems and questions that we need to discuss.
- I don't like being left alone in the treatment area.
- I have problems with my back / neck.
- I don't like the chair tipped back too far.
- I do not like to see dental instruments.
- Other concerns I would like to talk about (Please specify):

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