

TELL US ABOUT YOU

The better we understand you, your concerns and special circumstances, the better we will be able to serve you. We don't want to make assumptions about what's most important to you. Please make a mark on each scale below to indicate your opinion or preference.

<i>I know a great deal about my dental condition</i>	○ ○ ○ ○ ○ ○ ○ ○	<i>I know very little about my dental condition</i>
<i>I like to be presented with fewer options</i>	○ ○ ○ ○ ○ ○ ○ ○	<i>I like to be presented with more options</i>
<i>I tend to look at the details</i>	○ ○ ○ ○ ○ ○ ○ ○	<i>I tend to look at the big picture</i>
<i>I prefer long-lasting solutions which may cost more</i>	○ ○ ○ ○ ○ ○ ○ ○	<i>I prefer more temporary solutions at a lower cost</i>
<i>I prefer to talk in technical terms with my dentist</i>	○ ○ ○ ○ ○ ○ ○ ○	<i>I prefer to talk in non-technical terms with my dentist</i>
<i>My insurance largely determines the extent of my care</i>	○ ○ ○ ○ ○ ○ ○ ○	<i>I largely determine the extent of my care</i>
<i>I prefer to wait until I must act</i>	○ ○ ○ ○ ○ ○ ○ ○	<i>I usually see no reason to delay care</i>
<i>I rely more on self-maintenance</i>	○ ○ ○ ○ ○ ○ ○ ○	<i>I rely more on professional maintenance</i>
<i>I like newer and more modern techniques</i>	○ ○ ○ ○ ○ ○ ○ ○	<i>I prefer tried and true methods</i>
<i>I favor a treatment-oriented approach to disease</i>	○ ○ ○ ○ ○ ○ ○ ○	<i>I favor a cause-oriented approach to disease</i>
<i>I am open to considering optional or elective services</i>	○ ○ ○ ○ ○ ○ ○ ○	<i>I am only interested in the minimum necessary</i>

In prioritizing my dental health, I generally consider the following benefits

<input type="checkbox"/> <i>Comfort</i>	<input type="checkbox"/> <i>Appearance</i>	<input type="checkbox"/> <i>Peace of Mind</i>
<input type="checkbox"/> <i>Function</i>	<input type="checkbox"/> <i>Precision</i>	<input type="checkbox"/> <i>Health</i>
<input type="checkbox"/> <i>Durability</i>	<input type="checkbox"/> <i>Other</i>	

In choosing dental care, I generally weigh the following issues

<input type="checkbox"/> <i>Money</i>	<input type="checkbox"/> <i>Time</i>	<input type="checkbox"/> <i>Personal Effort</i>
<input type="checkbox"/> <i>Physical Discomfort</i>	<input type="checkbox"/> <i>Fear / Anxiety</i>	<input type="checkbox"/> <i>Other</i>

Notes: